PRINTED: 03/21/2018 FORM APPROVED OMB NO. 0938-0391

	OVIDER OR SUPPLIER	495413		G		
		433413	B. WING		C	
			1	STREET ADDRESS, CITY, STATE, ZIP CODE	05/04/2017	
AUTUMN C					•	
	CARE OF MECHANICSV	ILLE		7600 AUTUMN PARKWAY		
				MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	JMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		SHOULD BE COMPLETIC	ON	
F 000	INITIAL COMMENTS		F 0	00		
F 157	survey was conducted Complaints were inve Corrections are require following 42 CFR Para Care requirements. To survey/report will follow The census in this 16 155 at the time of the consisted of 22 currer (Residents #1 through	9 certified bed facility was survey. The survey sample not resident reviews no #21 and #27) and 5 closed dents #22 through #26).	F 1	57	5/26/17	
	consult with the reside consistent with his or representative(s) when (A) An accident involves results in injury and his physician intervention (B) A significant changemental, or psychosocideterioration in health status in either life-throllinical complications) (C) A need to alter treat a need to discontinue	ring the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or); eatment significantly (that is,				
ADODATORY	NDECTORIC OR RECY (SEE)	SUPPLIER REPRESENTATIVE'S SIGNATURE	-	TITLE	(X6) DATE	

Electronically Signed 05/26/2017 Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Facility ID: VA0409

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	COMP	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _		05/04/2017		
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 03/	0 4 /2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157	(D) A decision to tra resident from the fa §483.15(c)(1)(ii). (ii) When making no (14)(i) of this sectionall pertinent informatic is available and prophysician. (iii) The facility must resident and the resident in §483. (B) A change in resident (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMENT by: Based on staff interior and clinical record in the facility staff failed weight change, per	orm of treatment); or ansfer or discharge the cility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the at also promptly notify the sident representative, if any, or or roommate assignment a.10(e)(6); or addent rights under Federal or ions as specified in paragraph	F 1	F157 1. The physician was informed resident #14□s weight change. 2. All resident□s with physician report weight changes have the p	orders to		
	when the resident's two pounds from or	ed to notify the physician weight gain was greater than e day to the next or five n a week for Resident #14.		to be affected by this deficient pra Residents with orders for weight of notification have been reviewed for notification if needed 3. The DON or designee will ed licensed nurses on following MD of	change or MD lucate		

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	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP COI 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	DE	00/04/2017	
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F 157	10/24/16 with a readr diagnoses included be congestive heart failures piratory failure, fra blood pressure, sleep breathing while some chronic obstructive piratory failure piratory failure piratory failure piratory failure piratory failure piratory from the attrice of the heart output (2)). The most recent MDS assessment, a quarter assessment reference resident as scoring a interview for mental si was cognitively intact of the resident was coded as or set up assistance for most of She was coded as or set up assistance was the physician order of documented, "Obtain for monitoring. If ther (pounds) in one day of MD (medical doctor). The MAR (medication February 2017 documented aday for more gain of 2 lbs. in one conotify MD." The follo documented:	mitted to the facility on mission on 11/21/16. Her put were not limited to: are (CHF), acute and chronic acture of the lower leg, high of apnea (periods of not cone sleeps (1)), anemia, almonary disease (COPD), arapid and random aria of the heart causing ventricles decreasing the set of 3/14/17, coded the status) score, indicating she at to make daily decisions. Bed as requiring extensive of her activities of daily living. The area of 11/21/16, are weight daily; one time a day the is a weight gain of 2 lbs. For 5 lbs. in one week, notify	F 18	and notification of change of 4. The Unit Managers will a residents with orders to repo changes to the physician five weekly for four weeks, then r weekly for eight weeks. Resu will be carried to QAPI month months for review and revision necessary. 5. Date of compliance: June	audit all rt weight e times randomly ults of audits only for 3 ons as		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	L	3	S 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY 1ECHANICSVILLE, VA 23116	05/	04/2017
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F 157	pounds. The March 2017 MAF weight daily; one time there is a weight gain in one week, notify M gains were document 3/8/17 - 256; 3/9/17 - 3/16/17 - 257.8; 3/17/pounds. 3/17/17 - 260.2; 3/18/pounds. 3/26/17 - 252; 3/27/17 pounds. The April 2017 MAR of daily; one time a day weight gain of 2 lbs. in week, notify MD." The were documented: 4/3/17 - 252.8; 4/4/17 pounds. 4/7/17 - 256; 4/8/17 - The above order was Review of the nurse's 4/20/17 did not evided the physician being not the comprehensive of and revised on 3/21/1	R documented, "Obtain a day for monitoring. If of 2 lbs. in one day or 5 lbs. D." The following weight	F	157	DEFICIENCY)		
	characterized by fluid mucous membranes, integrity related to: di	volume deficit; dry skin and poor skin turgor and					

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F 157	RD (registered dietic facility routines." An interview was corpractical nurse) #4 of above daily weight of When asked what is the above order, LPN weigh the person evaccording to the order is documented, LPN in the progress notes. When asked if the 2d clinical record, LPN is both but definitely the Doth but definitely the Conducted with LPN #10 was asked to reweights. LPN #10 what the nurse's resimple in a day or five poun where this notification stated, "It should be say at least the doctor. The facility policy, "Conducted in part, recognize and approof a change in reside Physician/Family/Renotified as soon as the conducted in part.	ian) of weight change per inducted with LPN (licensed in 5/3/17 at 3:10 p.m. The reder was reviewed with her. expected of the nurse with N #4 stated, "We have to ery day and call the doctor er." When asked where that #4 stated, "It's documented is and or 24 hour book." If thour book was part of the expression of the	F 15	57				
	edition (Potter and P	sential for Practice, 6th erry, 2007, pages 56-59), rce for physician's orders and						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 157	information to the phy provider are causes of way to avoid being lia follow standards of cacare, and to communi providers. The physic is responsible for dire of a patient. Administrative staff m administrator, ASM #3, corporate no nurse) #3, the transition made aware of the ab 5:35 p.m.	o monitor the patient's by and communicate that resician or health care of negligent acts. The best ble for negligence is to are, to give competent health icate with other health care ian or health care provider cting the medical treatment	F.	157		
F 166 SS=D	Non-Medical Reader, Chapman, page 45. (2) Barron's Dictional Non-Medical Reader, Chapman, page 55. RIGHT TO PROMPT GRIEVANCES CFR(s): 483.10(j)(2)-((j)(2) The resident has must make prompt eff grievances the reside with this paragraph.	y of Medical Terms for the 5th edition, Rothenberg and ry of Medical Terms for the 5th edition, Rothenberg and EFFORTS TO RESOLVE (4) Is the right to and the facility forts by the facility to resolve nt may have, in accordance at make information on how complaint available to the	F	166		5/26/17

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F 166	resident. (j)(4) The facility must to ensure the prompt regarding the resident paragraph. Upon requation a copy of the grievance grievance policy must (i) Notifying resident in postings in prominent facility of the right to form (meaning spoken) or grievances anonymout of the grievance officity can be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the confide pendent entities where the filed, that is, the penduality Improvement Agency and State Lor program or protection (ii) Identifying a Griev responsible for overse receiving and tracking conclusions; leading a by the facility; maintait information associate example, the identity grievances submitted written grievance deceived.	restablish a grievance policy resolution of all grievances ts' rights contained in this uest, the provider must give be policy to the resident. The cinclude: Individually or through locations throughout the ide grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone expected time frame for of the grievance; the right cision regarding his or her ntact information of with whom grievances may ertinent State agency, Organization, State Surveying-Term Care Ombudsman and advocacy system; ance Official who is being the grievance process, a grievances through to their any necessary investigations ning the confidentiality of all divith grievances, for of the resident for those anonymously, issuing isions to the resident; and eand federal agencies as	F1	66		

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F 166	Continued From pag	e 7	F 10	66		
	prevent further potentight while the allege investigated; (iv) Consistent with § reporting all alleged values, including injurand/or misappropriat anyone furnishing se provider, to the admit as required by State (v) Ensuring that all valued the date the summary statement of the steps taken to investigated in the steps taken to investigate and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing the steps taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the date the writing taken by the facility and the da	483.12(c)(1), immediately violations involving neglect, ries of unknown source, ion of resident property, by rvices on behalf of the nistrator of the provider; and law; written grievance decisions grievance was received, a of the resident's grievance, vestigate the grievance, a nent findings or conclusions ht's concerns(s), a statement evance was confirmed or not ctive action taken or to be as a result of the grievance, ten decision was issued;				
	of the residents' right or if an outside entity the State Survey Age Organization, or loca	te law if the alleged violation is is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency or any of these residents' of responsibility; and				
	result of all grievance	ence demonstrating the es for a period of no less than ance of the grievance				

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	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		76	TREET ADDRESS, CITY, STATE, ZIP CODE 500 AUTUMN PARKWAY ECHANICSVILLE, VA 23116	,	· · · · · · · · · · · · · · · · · · ·
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F 166	This REQUIREMENT by: Based on staff intervireview, it was determ failed to maintain grie since the prior survey The facility staff could logs from April 2016 to the findings include: Upon entrance on 5/2 grievance policy and the last survey, OSM here on 1/2/17 and the last survey, OSM here on 1/2/17 and the aweek later, 1/9/17." An interview was constaff member (ASM) # ASM #2, the director a.m. When asked aborgievance, ASM #2 st grievance and give it grievance is forwarded department and they department head that and take action on it. resolution section is fikeeps the logs of the "Social Services." The #1, that the director of the services is the section of the "Social Services."	ew and facility document ined that the facility staff vance logs for six months. Inot locate the grievance intil November 2016. Inot locate the grievance intil November 2016. In at 12:30 p.m., the logs were requested. In other staff member (OSM) incial services, presented the 1/8/16 through present. In revious logs going back to #12 stated, "I just started the other social worker came that the administrator and for nursing, on 5/4/17 at 9:28 but the process for filing a lated, "Anyone can file a late any staff member. The did to the social services will give it to the proper relates to the grievance Action is taken until the liled in." When asked who grievances, ASM #2 stated, is surveyor informed ASM of social services could not a prior to 11/8/16; ASM #1	F 1	66	F166 1. Grievance/concern log current as January 2017. 2. All residents have the potential to affected by this deficient practice. 3. Facility staff educated on grievance/concern process by DON/designee. DON/designee to educate Social workers on maintaining grievance/concern log. 4. The grievance log will be audited to the Administrator or designee weekly for 12 weeks for accuracy and completent Results of audits will be taken to QAPI committee monthly for 3 months for review and revisions as necessary. 5. Date of compliance: June 16, 2017	be Dy or ess.	

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F 166	Continued From page 9		F 16	6		
	elsewhere for those.					
		mately 2:50 p.m. ASM #1 or, they could not locate any				
	Concerns" document strives to meet the ne representatives and se times that a concerning voiced without discrir resident or family. The residents, their representatives in the facility will invest concerns. Procedure representatives may his/her treatment, me residents, staff members.	filing grievances or concerns. tigate all grievances and e: A. Any resident or their file a concern regarding edical care, behavior of other oers, theft of property, etc. //Family Concern Form. 1.				
	locating the form, and B. The completed Rewill be forwarded to to investigate the concentration of the appearance of the	d documenting on the form. esident/Family Concern Form he facility Administrator to ern within 72. 1. The facility elegate the responsibility to				
	occurred; 2. The circ incident; 3. Where th Statements from the any witnesses and th Recommended corre outcome of the invested documented on the Form within 5 days a	umstances surrounding the e incident occurred; 4. resident; 5. The names of leir statements; 6.				

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F 166	documenting on the O 1. The following inform recorded on the log; a grievance/concern was and room number of the and relationship of the grievance/concern; discident occurred; exinvestigating the incident octome; g. The organization of the outcome; g. The organization of the grievance/concern." ASM #1 and ASM #2 above concern on 5/4 RIGHT TO SURVEY ACCESSIBLE CFR(s): 483.10(g)(10) (g)(10) The resident from the facility conducted surveyors and any planespect to the facility; (g)(11) The facility must be facility. (i) Post in a place real and family members a residents, the results the facility. (ii) Have reports with certifications, and contains a surveyor of the facility.	ritten grievances are al Services Department for Grievance/Complaint Logs. mation, as applicable, will be a. The date of the as received; b. The mane the resident; c. The name the person filing the The date the alleged The name of the person(s) tent; f. The date the tesentative was informed of disposition of the were made aware of the full of the the the sesult of the th		166			5/26/17

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F 167	= 167 Continued From page 11		F 1	67			
	years, and any plan of	of correction in effect with available for any individual					
	(iii) Post notice of the areas of the facility th accessible to the pub						
	information about cor This REQUIREMENT by: Based on observatio document review, it w facility staff failed to p availability of the last survey results and the corrections. A notice was not post responsible parties the three years of survey	e facility shall not make available identifying attion about complainants or residents. EQUIREMENT is not met as evidenced on observation, staff interview and facility ent review, it was determined that the staff failed to post a notice of the ility of the last three preceding year's results and their corresponding plan of ions. The was not posted to the residents and sible parties that the results of the previous ears of survey results, with the plan of ions, were available for review. In the facility shall not make available identifying the service of the interview.		F167 1. Posted signs were char that three years of survey re available for review. 2. All residents who desire survey results have the pote affected by this deficient pra 3. Administrator was in-se Regional Director of Clinical signage indicating 3 years or available for review. 4. Business Office Manage will audit signage weekly for assure signage is in place at visitors/residents. Results of carried to QAPI committee in	sults are to review intial to be ctice. rviced by Services of surveys er or design 12 weeks to disable to audits will	n nee to o be	
	binder labeled "State on the bottom shelf o lobby. No notice rega observed in the lobby On 5/2/17 at 2:45 P.M member) #1 (the adm was responsible for p ASM #1 stated the but on the bottom with the stated shelf of the stated sh	Inspection Results" located f a drop leaf credenza in the arding the survey results was 7. M., ASM (administrative staff ninistrator) was asked who posting the survey results. Usiness office manager was.		months for review and revisi necessary. 5. Date of compliance: Jur	ons as		
	On 5/2/17 at 2:48 p.m	ո., an interview was					

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 167	business office mashe was responsible results. OSM #4 survey results and when the administred was asked how made aware the survey results and the survey results at the survey results for the signs were postone the facility. At this the signs were postone the survey and the local to the survey and the survey at the surveys. On 5/3/17 at 5:42 put director of nursing of clinical services (the transitional cal aware of the above what should be doregarding the surveys.	M (other staff member) #4 (the nager). OSM #4 was asked if le for posting the survey tated she makes copies of the places them in the binder rator gives them to her. OSM residents and families are urvey results are available. survey results are located "up nza. OSM #4 was asked if ices posted that documented are available for review. OSM to know of." When asked if ices posted on the nursing	F	167		

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AUTUMN (CARE OF MECHANICSV	ILLE			IECHANICSVILLE, VA 23116		
040.15	CLIMMADY CT.	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 167	Continued From page	e 13	F 1	167			
	the survey results we council meetings. Wh should document, AS last three years are at the white book in the	titled, "RESIDENT					
	Facility that all Reside rights and privileges findings in any Center	d, "Is the policy at this ents shall have the following .To be notified of the rs for Medicare & Medicaid investigations concerning					
		n., ASM #3 stated the facility regarding the survey results.					
F 226 SS=D	DEVELOP/IMPLMEN	n was presented prior to exit. IT ABUSE/NEGLECT, ETC -(3), 483.95(c)(1)-(3)	F 2	226			5/26/17
	483.12 (b) The facility must d written policies and pr	levelop and implement rocedures that:					
		ent abuse, neglect, and nts and misappropriation of					
	(2) Establish policies investigate any such a	•					
	(3) Include training as §483.95,	required at paragraph					
	483.95						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '		(X3) DATE SURVEY COMPLETED		
		495413 B. WING		NG		C 05/04/2017	
	ROVIDER OR SUPPLIER	CSVILLE		STREET ADDRESS, CITY, STATE, ZIP C 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	010-1/2011	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 226	the freedom from requirements in § provide training to educates staff on- (c)(1) Activities that exploitation, and reproperty as set for (c)(2) Procedures neglect, exploitation, resident property (c)(3) Dementia magnetic property (c)(4) Procedures (c)(5) Procedures (c)(6) Procedures (c)(6) Procedures (c)(6) Procedures (c)(6) Procedures (c)(6) Procedures (c)(6) Procedures (c)(7) Procedures (c)(7) Procedures (c)(8) Procedures (c	t, and exploitation. In addition to abuse, neglect, and exploitation 483.12, facilities must also their staff that at a minimum at constitute abuse, neglect, nisappropriation of resident that § 483.12. for reporting incidents of abuse, on, or the misappropriation of an agement and resident abuse ENT is not met as evidenced the facility document rmined, that the facility staff at the facility abuse policy for the five employee records by the staff of the employee record the employee was hired on the license was verified as being the staff of the employee was hired on the license was verified as being	F 2:	F226 1. The license verification was in the employee s file 2. All residents have the affected by this deficient pr 3. The Administrator or deducate human resource department managers on verification/licensure prior 4. Human Resources/despotential new employee sweekly for completeness and Audits will be taken to QAP monthly times 3 months for revisions as necessary. 5. Date of compliance: July 100 months to the compliance of the compliance	potential to be ractice. esignee will epartment and verification of to hire. signee will audit paper work accuracy. PI committee r review and		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		76	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	in the file we don't had original in the file and When asked why state to hire, OSM #13 state actually have a valid for the number of shir residents before the 15/4/17 at 1:00 p.m. Or received. CNA #7 wo days prior to having the director of nursing employees were screed that the director of nursing employees were screed to from a criminal." When were obtained, ASM ideally are going to fing you are hiring." ASM findings at that time. Review of the facility' Resident Abuse Polic This Facility will not the mistreatment, exploit misappropriation of reprocedure. I. So employ or otherwise been found guilty of a mistreatment of reside finding of abuse, negexploitation, involuntation in the procedure aide registry, of taken against a profelicensure body as a reference of the facility of the facility of the facility of the facility will not the facility will not the facility will not the facility will not the facility of	OSM #13 stated, "If it's not ve it. We always keep the I put a red line through it." Iff licenses are verified prior ted, "To make sure they license. A request was made its CNA #7 worked with the icense was verified. On NA #7's schedule was rked with residents for 6 he license verified. ducted on 5/4/17 at 2:07 nistrative staff member) #2, g. When asked why references was aked why references was made aware of the license verified. sen asked why references was titled, "References was aked why references was made aware of the spolicy titled, "Virginia by" documented, "POLICY: colerate abuse, neglect, ation of residents, and esident property by anyone. I reening-facility will not engage individuals who have abuse, neglect, or ents by a court of law; had a lect, mistreatment,	F	2226			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495413	B. WING		C 05/04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	03/04/2017
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F 241 SS=D	is the policy of the Fabackground checks of on file applicable recording such check following prior to hirin Check with the applicate registry, and any other that the Facility has reinformation on an individual as a nurse. No further information DIGNITY AND RESP CFR(s): 483.10(a)(1) (a)(1) A facility must the resident in a manner promotes maintenancher quality of life recondividuality. The facility promotes the rights of This REQUIREMENT by: Based on observation document review, it we facility staff failed to put dignified manner for consurvey sample, Resident and buttock for the facility staff documents and the faci	ropriation of property. 1.) It cility to undertake fall employees and to retain ords of current employees s. a. The Facility will do the g a new employee ii. able nurse assistant registries eason to believe contain vidual, prior, to using the assistant." In was obtained prior to exit. ECT OF INDIVIDUALITY Treat and care for each and in an environment that the er enhancement of his or gnizing each resident's ity must protect and the resident. In is not met as evidenced In the staff interview and facility are determined that the rovide wound care in a one of 27 residents in the lent #7. In the staff interview and the ent #7. In the staff interview and facility are determined that the rovide wound care in a one of 27 residents in the lent #7.	F2	F241 1. LPN #10 was in-serviced and counseled by the DON on providing wound care in a dignified manner. 2. All residents receiving wound treatments have the potential to be affected by this deficient practice. 3. The DON or designee will in-ser licensed nurses on providing wound in a dignified manner.	care
		uitted to the facility on 1/7/15 ocluded but were not limited		Unit Manager/designee will obsorbed 25% of wound treatments weekly for weeks and randomly for eight weeks assure compliance. Results of audits	four to

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		5/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	chronic pain, gastroe anemia (too low bloo of the sacral region (i bony prominence respressure to the area dementia. The most recent MDS assessment, a quarte assessment reference resident as a zero on mental status) score, severely impaired to decisions. Resident extensive assistance members for all of hes Section M - Skin Concoded as having an unalso known as a presidull-thickness skin an Full-thickness skin an extent of tissue dama be confirmed because eschar. If slough or a 3 or Stage 4 pressure Stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable of the skin and usually over a bony pressure stable of the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and usually over a bony pressure stable eschar (i.e. drerythema or fluctuand limb should not be so the skin and the stable eschar (i.e. drerythema or fluctuand limb should no	od pressure, depression, sophageal reflux disease, d count (1)), pressure ulcer inflammation or sore over a ulting from prolonged (2)), dysphagia, and S (minimum data set) erly assessment, with an e date of 2/3/17, coded the the BIMS (brief interview for indicating that she was make cognitive daily from was coded as requiring of one or more staff er activities of daily living. In indications, the resident was unstageable pressure ulcer*.	F 2		ee monthly for risions as		
	members for all of he Section M - Skin Concoded as having an ualso known as a pressure stable eschar. If slough or east a stable eschar (i.e. dreythema or fluctuand limb should not be so the skin ausually over a bony paredical or other devias intact skin or an output of the skin of the skin or an output of the skin or an output of the skin or a	er activities of daily living. In additions, the resident was unstageable pressure ulcer*. It is used in the living of the livin					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		76	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		V 1/2011
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F 241	tissue for pressure ar affected by microclim co-morbidities and the unit in nurse; on 5/3/17 at 10 proceeded to perform treatment to her bilate LPN #10 completed explaced the dressings proceeded to write or the sacral dressing, vinitials and the date of the sacral dressing it on the resident, like the sacrated, "I should have putting it on the resident marker) out of my powould feel if someone area or heels, LPN # On 5/4/17 at 10:25 at conducted with RN (remanager. RN #8 was date a dressing durin stated, "I date them president." When asked why starit is on a resident, RN	ar. The tolerance of soft and shear may also be ate, nutrition, perfusion, ondition of the soft tissue. (4) de of LPN (licensed practical manager and wound care 0:50 a.m. LPN #10 and Resident #7's wound care eral heels and sacrum. After each of the dressings, she on the resident. She then an both heel dressings and with a permanent marker, her of 5/3/17. ducted with LPN #10 on When asked if a nurse is a dressing while it is on the rum or heels, LPN #10 edated the dressing before ent. I was afraid to break the sharpie (permanent cket." When asked how she eraws writing on her sacral 10 did not respond. m., an interview was registered nurse) #8, a unit is asked when staff would g a dressing change. RN #8 when to putting it on the end if staff should write on a lafter it has already been at, RN #8 stated, "No." Iff don't date a dressing while if #8 stated, "It can cause the of the pen or marker and	F	241			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED C	
		495413	B. WING		l) 04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICS	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 241	The facility policy, "Fin part, "IT is the polithat resident will be an environment that enhancement of each (Name of corporation that the resident's right aware protected. Guidance is given to of dignity in "Fundar Edition, Potter Perry guidance is, "Nurses self-esteem and dignas a whole person waccomplishments, at the illness experience. Administrative staff administrator, ASM ASM #3, the corpora transitional care coordinated the above findings of the above findings of the company page 33. (1) Barron's Dictional Non-Medical Reade Chapman, page 33. (2) Barron's Dictional Non-Medical Reade Chapman, page 155.	RN #8 stated, "Yes, it would." Resident Rights" documented icy of (name of corporation) cared for in a manner and in promotes maintenance or ch resident's quality of life. In) is committed to assuring ghts articulated under federal on nurses for the preservation mentals of Nursing, 7th yp. 476." Included in the spromote a client's nity by respecting him or her with feelings, and passions independent of ite." Indicate the director of nursing, attenurse and RN #3, the ordinator, were made aware of ite 5/3/17 at 5:35 p.m. In was provided prior to exit. In any of Medical Terms for the r, 5th edition, Rothenberg and in any of Medical Terms for the r, 5th edition, Rothenberg and in any of Medical Terms for the r, 5th edition, Rothenberg and in any of Medical Terms for the r, 5th edition, Rothenberg and	F 24			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495413	B. WING _		C 05/04/2017
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 03/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 241	following website: http://www.npuap.org clinical-resources/np	was obtained from the g/resources/educational-and- uap-pressure-injury-stages/	F 2		
F 248 SS=D	ACTIVITIES MEET II EACH RES CFR(s): 483.24(c)(1) (c) Activities.	NTERESTS/NEEDS OF	F 2	48	5/26/17
	comprehensive assethe preferences of eaprogram to support reactivities, both facility individual activities at designed to meet the physical, mental, and each resident, encou and interaction in the This REQUIREMENT by: Based on observation interview, facility docrecord review, it was staff failed to provide program designed to interests for two of 25 sample, Residents #4 1. The facility staff faractivities individualized interests.	on, resident interview, staff ument review and clinical determined that the facility an ongoing activities meet residents' needs and residents in the survey 4 and #7. illed to involve Resident #4 in ed to meet the resident's		F248 1. Residents #4 and #7 were a for activity preferences and care were reviewed for accuracy. 2. All residents have the poter affected by this deficient practic. 3. The MDS Coordinator or de in-service the Activity Director a Activities staff on completing an documenting activity assessment documenting resident participation updating care plans. 4. The MDS Coordinator or de audit 10% of care plans and act assessments weekly for four we then randomly for eight weeks to	e plans ntial to be e. esignee will nd the d nts, ion, and esignee will ivity eeks, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 05/04/2017	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	5/04/2017	
	10 115211 011 001 1 21211			7600 AUTUMN PARKWAY			
AUTUMN (CARE OF MECHANICSV	ILLE		MECHANICSVILLE, VA 23116			
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F 248	Continued From page	21	F 2	48			
	activities individualize interests.	led to involve Resident #4 in d to meet the resident's		that information regarding activity recorded. The Director of Social conduct audits of participation letimes weekly for four weeks, the randomly weekly for eight weekly	al Work will og five en ss to		
		's diagnoses included but		assure that they are complete. audits will be carried to the QAF	기		
	Resident #4's most reset), a quarterly assessment reference the resident's cognitic Section G coded Resextensive assistance mobility and locomotion	and overactive bladder. Except MDS (minimum data assement with an ARD are date) of 3/21/17, coded on as severely impaired. Exident #4 as requiring of one staff with bed on. Resident #4's annual		committee monthly for 3 months review and revisions as necess 5. Date of compliance: June 2	ary.		
	as being cognitively in Resident #4 as requir staff with bed mobility help with locomotion. activity preferences w assessment for activity Resident #4 preferred limited to: reading, lis	12/19/16 coded the resident ntact. Section G coded ing limited assistance of one and supervision with set up. The resident interview for reas not completed. The staff ty preferences documented a activities including but not tening to music, being ing up with the news and res.					
	reveal any documents department (including evidence of participat	olan initiated on 4/28/16					
	On 5/2/17 at 5:15 p.m observed lying in bed On 5/3/17 at 11:25 a.	and watching television.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIF 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	CODE	
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F 248	On 5/3/17 at 2:27 p.m (the MDS coordinator activity notes in Residence of Signature	a., RN (registered nurse) #2 c) confirmed there were not dent #4's clinical record. a., an interview was (other staff member) #2 (the SM #2 was asked to provide nation to evidence Resident ites. OSM #2 confirmed she documentation. OSM #2 referred to stay in her room. If she had completed any ent #4's activity preferences resessment that was 19/16 MDS. OSM #2 stated itted to the facility prior to byment. OSM #2 stated she erly progress notes but they owing up on the computer. her employment she had #4 activities. OSM #2 was ident #4's 12/19/16 MDS	F2	248	NCY)	
	visits with Resident # activities director prev have had documental resident's activity part could not provide the On 5/3/17 at 2:40 p.m	4. OSM #2 stated the viously employed should tion to evidence the ticipation but she (OSM #2)				

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	ROVIDER OR SUPPLIER	VILLE	;	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 248	resident was asked activities that she wroom. Resident #4 asked what activities stated, "I don't know On 5/3/17 at 5:42 p. member) #1 (the addirector of nursing), of clinical services) (the transitional care aware of the above The facility policy tit Protocol" document promote the physica well-being of resider conducted and on-gmaintained for each Procedure: - Within 3 days of a facility, an Activity A form (MP 5450), will develop an activities and interests of the - The resident's Actic conducted by Activitic conjunction with oth related factors such and medical conditic participation. The respirituality, life roles activity pursuit patter included in the asset-Each resident's Activity Assessible activity Assessi	if there were any particular ould like to be provided in her stated, "Maybe." When a she would like, the resident if I can't think right now." m., ASM (administrative staff ministrator), ASM #2 (the ASM #3 (the regional director and RN (registered nurse) #3 e coordinator) were made findings. led, "Activity Documentation ed "Purpose: In order to al, mental and psychosocial ints, an Activity Assessment is oing documentation is resident. resident's admission to the ssessment utilizing Med Pass I be conducted to help a plan that reflects the choices resident. vity Assessment is to be by Department personnel, in the staff who will assess as functional level, cognition, ons that may affect activities esident's lifelong interests, goals, strengths, needs and and preferences will be ssment ivities Care Plan shall relate ensive Assessment and	F 248		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 248	-Activity progress not minimal every 3 mon documentation when No further informatio 2. The facility staff fa was provide with an attention with diagnoses that in the diagnoses	rvention from the facility te needs to be written at ths, including MDS section F is completed" In was presented prior to exit. illed to evidence Resident #7 activity program. Initted to the facility on 1/7/15 included but were not limited od pressure, depression, isophageal reflux disease, discount (1)), pressure ulcer inflammation or sore over a sulting from prolonged (2)), dysphagia, and S (minimum data set) erly assessment, with an eric date of 2/3/17, coded the on the BIMS (brief interview ore, indicating that she was make cognitive daily #7 was coded as requiring of one or more staff er activities of daily living. MDS assessment, a seessment, a seessment, with an eric date of 7/20/16, coded the "6" on the BIMS, indicating paired to make cognitive ection F - Preferences for and Activities the resident in the facility, the resident felt	F 24			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 5/04/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			03/04/2017	
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F 248	to read, listening to n keep up with the new people, do her favorif fresh air when the we participate in religiou. The comprehensive with a revised on dat part, "Focus: Resider solitary activities; wa area and talking to of "Interventions" docur group activities. Offe toward specific intere Provide and encoura (as needed). Resider calendar." Resident #7's room v 5:04 p.m. The reside resident was then ob hallway in her wheeld greeted her. Other rethe dining tables for on 5/3/17 at 7:42 a.m.	ing books and newspapers husic, be around animals, its, do things with groups of the activity, go outside to get eather is good, and its services or practices. Care plan, dated, 4/26/16 are of 2/21/17, documented in ant enjoys the following tothing TV in the living room their residents." The mented, "Engage resident in are activity program directed ests/needs of resident. ge visits for socialization pronout will receive monthly Vas observed on 5/2/17 at ant was not in the room. The served on the side of the chair. A staff member esidents were gathering at dinner. In the resident's room was was dark with the curtains	F 24				
	On 5/3/17 at 10:50 at observed in bed. The morning care had jus						
	in the hallway in her	n. the resident was observed wheelchair, trying to sidents were in the living					

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		495413	B. WING		C 05/04/2017	
	ROVIDER OR SUPPLIER	/ILLE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	03/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 248	Continued From page room area watching to		F 248			
		n. the resident was observed wheelchair not engaged in				
	member (OSM) #2, the When asked where in #7's activities were down and individual asked if she had any Resident #7 attends, "Occasionally she will she does not attend asked what the activities asked what the activities in the weight asked what the activities in the weight asked where it is a weight asked where weight asked where it is a weight ask	inducted with other staff the director of activities. Inotes regarding Resident ocumented, OSM #2 stated, or quarterly notes. We keep a when the residents attend flog for each person." When idea of what activities OSM #2 stated, Ill come to music activities, on a daily basis." When ty department does for 2 stated, "I'll have to get back				
	records of attendance #7, but the records we asked where Resider to attend activities we #2 stated, "I am told she declines activities be documented, OSM no log for her." When evidence of any activattended activities for #2 stated, "Nom Ma's	n. OSM #2 presented e at activities for Resident were all for 2016. When nt #7's attendance or refusal ould be documented, OSM by the other activity staff that s." When asked if this should M #2 stated, "Yes. We have n asked if she could provide rities Resident #7 had r the last three months, OSM am, I can't tell you if she has he last three months."				
	administrator, ASM # ASM #3, the corpora	nember (ASM) #1, the 2, the director of nursing, te nurse and RN #3, the dinator, were made aware of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	SURVEY
	495413	B. WING _		1	C /04/2017
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVII	LLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		0.772011
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(1) Barron's Dictionary Non-Medical Reader, Chapman, page 33. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 155. F 278 SS=E F 278 SS=E ASSESSMENT ACCURACY/COORDICER(s): 483.20(g)-(j) (g) Accuracy of Assessmust accurately reflection (h) Coordination A registered nurse muleach assessment with participation of health (i) Certification (1) A registered nurse the assessment is conducted in the coordination (2) Each individual whassessment must sign that portion of the assessment in the coordination (1) Under Medicare are who willfully and know (i) Certifies a material	was provided prior to exit. of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and INATION/CERTIFIED sments. The assessment the resident's status. st conduct or coordinate the appropriate professionals. must sign and certify that inpleted. o completes a portion of the and certify the accuracy of essment. attion and Medicaid, an individual ringly- and false statement in a subject to a civil money		278		5/26/17

AND PLAN OF CORRECTION INTERPRETATION NUMBERS		` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 5/04/2017	
	ROVIDER OR SUPPLIER	ILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			1 03/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278	and false statement is subject to a civil mon \$5,000 for each assection of the statement is subject to a civil mon \$5,000 for each assection of the statement is subject to a civil mon \$5,000 for each assection and the statement is subject to a civil mon is subject to the statement is subject to a civil mon is subject to	ndividual to certify a material in a resident assessment is ey penalty or not more than issment. Intent does not constitute a satement. This not met as evidenced riew and clinical record sined that the facility failed to indicated the modern in the survey 12, # 4, # 10 and # 16. It is not met as evidenced riew and clinical record sined that the facility failed to indicate the modern in the survey 12, # 4, # 10 and # 16. It is not met as evidenced riew and clinical record in the survey 12, # 4, # 10 and # 16. It is not met as evidenced riew and clinical record in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 4, # 10 and # 16. It is not met as evidenced to in the survey 12, # 10 and # 16. It is not met as evidenced to in the survey 12, # 10 and # 16	F 278	F278 1. The MDS of residents #12 and #16 were reviewed and cl made to ensure accuracy. 2. All residents have the pot affected by this deficient pract 3. The MDS department and were in-serviced by Regional on an accurate and complete 4. The MDS Coordinator or audit MDS completion weekly weeks, then randomly weekly weeks to assure completion a accuracy. The results of the ataken to the QAPI committee of 3 months for review and revision needed 5. Date of compliance: June	ential to be ice. If IDCP team MDS Nurse MDS. designee will for four for eight audits will be monthly for on as		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 278	Continued From pag	e 29	F 278	3		
	MDS (Minimum Data ARD (assessment read ARD (assessment read ARD (assessment read ARD (assessment read ARD (assessive disorder, disease (4).) The most recent condata set), an admiss (assessment referent the resident as scori interview for mental and a ARD (assessment referent the resident as a ARD (assessment read ARD	ailed to complete the Resident # 12's quarterly a Set) assessment with the eference date) of 01/24/17. dmitted to the facility on eses that included but not (1), heart disease (2), anxiety (3), and Parkinson's apprehensive MDS (minimum ion assessment with an ARD ce date) of 04/29/16 coded and a three on the brief estatus (BIMS) of a score of 0 erely impaired of cognition. oded as requiring limited aff member for activities of				
	quarterly assessmer reference date) of 01 completion of Section Further review of sector through C1000 was On 05/03/17 at 4:15 conducted with LPN 9, MDS nurse. LPN Sections C0100 through Patterns" of Resident assessment with an asked why Sections "Cognitive Patterns" stated, "I was responsible to the complete of the	S (minimum data set), a at with an ARD (assessment 1/24/17 failed to evidence the n C "Cognitive Patterns." etion C revealed C0100 blank. p.m. an interview was (licensed practical nurse) # # 9 was asked to review ugh C1000 "Cognitive t # 12's quarterly MDS ARD of 01/24/17. When C0100 through C1000 was not completed. LPN # 9 nsible for that. It should have //hen asked what guidance				

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F 278	stated, "We use the Finstrument) manual." 2. The facility staff fai	e 30 eting the MDS LPN # 9 RAI (resident assessment led to attempt the resident d activity preferences on	F2	278			
	Resident #4's annual	MDS (minimum data set) ARD (assessment reference					
	1/21/15. Resident #4 were not limited to: h depressive disorder a Resident #4's most re assessment with an A resident's cognition a a six out of a possible interview for mental s Resident #4's annual 12/19/16 coded the reintact, scoring a 15 o BIMS assessment. Sas being understood others. Section F300 Interview for Daily an Conducted? - Attempable to communicate complete, attempt to family member or sig (resident is rarely/net family/significant other	and overactive bladder. ecent MDS, a quarterly ARD of 3/21/17, coded the s severely impaired, scoring e 15 on the BIMS (brief status) assessment. MDS with an ARD of esident as being cognitively out of a possible 15 on the section B coded Resident #4 and as understanding of documented, "Should d Activity Preferences be out to interview all residents out of the state of the section of the secti					
	conducted with RN (r	n., an interview was egistered nurse) #2 (the N #2 was asked how to					

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F 278	staff interview sho assessment. RN a resident's BIMS or resident couldn't at then she would co RN #2 was asked would have to sco to attempt the interview and it de answer the question answered the queshould have atternactivity preference the MDS with an A"I would say yes." On 5/3/17 at 2:11 conducted with Os activities director a completing section OSM #2 stated sh interview for daily feels she can obtathe resident. OSM staff assessment for preferences if a rewhere she can't ur resident is in the hworked at an assis employment at this previous experience assessments. Os not attempt Reside activity preference assessment with a second could be assessment with a session of the second could be activity preference assessment with a session of the second could be activity preference assessment with a second could be activity as a second co	age 31 r a resident interview versus a uld be conducted for an MDS #2 stated she would look at the in the MDS assessment and if a inswer the interview questions implete the staff assessment. What number the resident if the resident if the resident scored a five on a may consider the staff pended on if the resident could ons or how the resident stion. RN #2 was asked if staff pted the interview for daily and is with Resident #4 regarding in interview was interview in interview in interview in interview in interview in interview interview in interview interview interview in interview	F 2	78		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		, ,	TE SURVEY MPLETED		
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F 278	she is now more exprehenter to complete the staff assessment have completed Resipreference interview stated she references has questions while cassessments. On 5/3/17 at 2:24 p.m references the CMS Medicaid Services) Roustrument) manual vassessments. On 5/3/17 at 5:42 p.m member) #1 (the admirector of nursing), A of clinical services) a (the transitional care aware of the above fith the CMS RAI manual SECTION F: PREFECUSTOMARY ROUT Intent: The intent of it obtain information respreferences for his of activities. This is best information is obtained or through family or sinterviews if the residupreferences. The information homes should create an individualization.	go home. OSM #2 stated erienced in determining the resident interview versus and she probably should dent #4's daily and activity with the resident. OSM #2 is the MDS coordinator if she completing MDS In. RN #2 stated she (Centers for Medicare & Al (Resident Assessment when completing MDS In., ASM (administrative staff ministrator), ASM #2 (the ASM #3 (the regional director and RN (registered nurse) #3 coordinator) were made andings. Indicate the following: ERENCES FOR TINE AND ACTIVITIES tems in this section is to garding the resident's the directly from the resident ignificant other, or staff ent cannot report ormation obtained during this tion of the assessment. In duse this as a guide to	F 2	78		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 278	Preferences Be Cor Item Rationale Health-related Quali Most residents capa answer questions al Obtaining informatio from the resident, so resident's voice,' is to way of identifying profession of the resident cannot significant other who be able to provide upreferences. Planning for Care Quality of life can be respects the resident that is important to to Interviews allow the reflected in the care Information about puffrom the resident profession of the resident profession of the resident profession of the resident profession. Determine whe rarely/never understood and familitem F0800, Staff As Activity Preferences 102. Conduct the imperiod. 103. Review Langua whether or not the residents and so the resident profession.	riview for Daily and Activity inducted? ity of Life able of communicating can bout what they like. In about preferences directly ometimes called 'hearing the the most reliable and accurate references. communicate, then family or to knows the resident well may seful information about a greatly enhanced when care in the choice regarding anything the resident. resident's voice to be plan. references that comes directly ovides specific information for care and activity planning. In the ether or not resident is tood and if family/significant resident is rarely/never for the communication of	F 278			
	understood and famitem F0800, Staff As Activity Preferences 102. Conduct the imperiod. 103. Review Langua whether or not the minterpreter. If the resinterpreter, complete interpreter.	nily is not available, skip to a seessment of Daily and it. terview during the observation age item (A1100) to determine				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTR		(X3) DATE SURVEY COMPLETED			
		495413	B. WING		C 05/04/2017	
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F 278	verbally, by pointing card, OR by writing No further information The RAI (Resident Amanual documented PATTERNS. Intent: intended to determine orientation and ability information. These is many care-planning On 05/04/17 at appreciation of the series of	to their answers on the cue out their answers" on was presented prior to exit. Assessment Instrument) d, "SECTION C: COGNITIVE The items in this section are ne the resident's attention, ty to register and recall new tems are crucial factors in decisions." roximately 1:50 p.m. ASM member) # 1 the ASM # 2, director of nursing, f the findings. on was provided prior to exit.	F 278			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 278	Continued From page	e 35	F 27	78		
F 278	from the website: https://medlineplus.go (3) Fear. This inform. website: https://www.nlm.nih.g #summary. (4) A type of moveme information was obtai https://www.nlm.nih.g sease.html. 3. The facility staff fai Resident # 10 had tw significant change MI assessment with an A date) of 4/21/17. Resident # 10 was ac 1/14/16 and again on included, but were no dementia, anxiety, de coronary artery disea hypothyroidism [a low Resident # 10's most	ation was obtained from the ov/medlineplus/anxiety.html ant disorder. This ned from the website: ov/medlineplus/parkinsonsdi led to accurately record that o falls in Section J on her DS (minimum data set) ARD (assessment reference limitted to the facility on 4/14/17 with diagnoses that t limited to, hypertension, pression, atrial fibrillation, se, seizures, and of functioning thyroid (1)].	F 27	78		
	Resident # 10 was counderstanding and as others. Resident # 10 out of a possible 15 of for Mental Status) ind was severely cognitive J1800: (Any Falls sing Reentry or Prior Asset	with an ARD of 4/21/17. Ided as usually s usually able to understand to was coded as scoring zero in the BIMS (Brief Interview licating that Resident #10 lely impaired. Section the Admission/Entry or lessment) coded Resident of falls since the last MDS				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	falls dated 1/23/17 at MDS assessment with During an interview of RN (registered nurse Resident # 10's signit was reviewed. RN # "an item coding error reference she (RN # MDS assessments. (resident assessment) During the end of dap.m. with ASM (admitte administrator, AS nurses, ASM # 3, registervices, and RN (restransitional care coor revealed.		F 27			
	Reentry or Prior Asson Budget Reconciliation [Prospective Paymer more recent (cont.) Planning for Care: " Identification of of falling is a top prior previous fall is the more future falls. " Falls may be an	ce Admission/Entry or essment (OBRA [Omnibus n Act] or Scheduled PPS nt Systems]), whichever is residents who are at high risk rity for care planning. A ost important predictor of risk indicator of functional decline other serious conditions such				

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F 278	Continued From page	e 37	F 2	78		
	as delirium, adverse and infections. "External risk fact effects, use of appliant environmental condit. "A fall should stim resident's need for remodification of the phadditional monitoring incontinence). Steps for Assessment. 1. If this is the first as review the medical rethe admission date to the admission date to the admission date to the last MDS assessicurrent assessment. 3. Review all available the last assessment, occurred while out in hospital, or in the nurrecords generated in since last assessment. 4. Review nursing ho and the medical records the records of falls should be caped to falls should the medical records and the medical records falls should be caped to falls should be caped to falls should the medical records and the medical records the resident and the medical records and the resident	drug reactions, dehydration, tors include medication side inces and restraints, and ions. inulate evaluation of the inabilitation, ambulation aids, inysical environment, or (e.g., toileting, to avoid it: sessment (A0310E = 1), icord for the time period from io the ARD. It assessment (A0310E = 0), irom the day after the ARD of ment to the ARD of the e sources for any fall since no matter whether it the community, in an acute sing home. Include medical any health care setting it. ime incident reports, fall logs rd (physician, nursing,				

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F 278	fall since the last ass Disorder item (K0100" Code 1, yes: if the last assessment. since Admission/Entr Assessment (OBRA (J1900), whichever is Examples: 1. An incident report Mr. S. was walking deslip on a wet spot on and bumped into the onto the hand rail and Coding: J1800 would Rationale: An interce (1) This information website:https://www.ry/article/000353.htm 4. The facility staff fainterview portion of S Customary Routine a #16's 4/19/17 admission.	e resident has not had any essment. Skip to Swallowing I). The resident has fallen since Continue to Number of Falls by or Reentry or Prior or Scheduled PPS) item as more recent. In describes an event in which own the hall and appeared to the floor. He lost his balance wall, but was able to grab disteady himself.	F 278	,	
	4/12/17 with the diag sepsis, cellulitis, end diabetes, high blood The most recent MDS an admission/5-day a (Assessment Referen	noses of but not limited to			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP C 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	ODE	00.0 11.20 11
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F 278	out of a possible 15 for Mental Status) excoded as requiring etransfers, dressing, it supervision for eating. A review of Resident assessment revealed Section B "Hearing, to make herself under understand others. Further review of the the resident interview for Customary Routin completed. The staff completed instead. Interview for Daily ar Conducted?" The resident is rarel family/significant oth resident should have Continue to F0400, Preferences." On 5/4/17 at 10:58 at conducted with OSM activities director. With (Resident #16), When asked if she are resident for Section is she attempted to intended the resident interview guide to use when coassessment, if she is	life decisions, scoring a 13 on the BIMS (Brief Interview fam. The resident was extensive assistance for hygiene and bathing; g. ##16's above identified MDS of the resident was coded in Speech, and Vision" as able erstood and able to #MDS assessment, revealed of for Section F "Preferences the and Activities" was not if interview section was in Section F0300 "Should and Activity Preferences be esident was coded as "0" for y/never understood and the rot available). The is been marked as "1" for "Yes Interview for Daily ##2 (Other Staff Member) the profession of the MDS, she stated that the stated she wasn't sure. The stated she wasn't sure. The profession of the MDS, she stated that the sep. She did not document ther attempts to complete with when asked if she has a	F 2	278		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	1, ,	E SURVEY PLETED	
		495413	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	430410	I B: Wille	STREET ADDRESS, CITY, STATE, ZIP CODE	05	5/04/2017	
	CARE OF MECHANICSV	ILLE		7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 278	usually asked the MD On 5/4/17 at 11:05 a. #2 (Registered Nurse that they have 7 to 8 assessments done ar be attempted multiple facility uses the RAI MASSESSMENT Instrumed and that all departme of the MDS are aware the manual. According to the CMS Medicaid Services) R Instrument) MDS 3.0 RAI Users Manual do page F-1 through F-3 about preferences dir the most reliable and preferencesQuality enhanced when care	m., in an interview with RN) the MDS nurse, she stated days to get the MDS nd that the interviews should times. She stated the Manual (Resident ent) for completing the MDS nts which complete sections of this and have access to G (Centers for Medicare and AI (Resident Assessment Manual, Section F of the cuments the following on : "Obtaining information ectly from the residentis accurate way of identifying of life can be greatly respects the resident's	F:	278			
F 280 SS=D	resident. Interviews a be reflected in the car to lifestyle preference depressed mood and symptoms." On 5/4/17 at 1:52 p.m (Administrative Staff I Director of Nursing (A of the findings. No fu provided by the end of RIGHT TO PARTICIP CARE-REVISE CP	increased behavior a., the Administrator Member [ASM] #1) and the aSM #2) were made aware rther information was of the survey.	F:	280		5/26/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495413	B. WING			C 05/04/2017	
	ROVIDER OR SUPPLIER	L		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116	<u> U5/</u>	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	and implementation of plan of care, including the right to participate including the right to it be included in the plan request meetings and revisions to the person (ii) The right to participate and amount, frequency, and other factors related the plan of care. (iv) The right to receivance included in the plan of care. (v) The right to see the right to sign after sign of care. (c)(3) The facility shall right to participate in light to participate in ligh	ticipate in the development of his or her person-centered of but not limited to: Date in the planning process, dentify individuals or roles to nning process, the right to of the right to request on-centered plan of care. Pate in establishing the autcomes of care, the type, and duration of care, and any of the effectiveness of the We the services and/or items of care. The care plan, including the difficant changes to the plan Il inform the resident of the his or her treatment and dent in this right. The ost sion of the resident and/or	F	280			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY	
		495413	B. WING	B WING		C 05/04/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u> U5/</u>	04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE	
F 280	the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and the range and their resident repont practicable for the resident's care plan. (F) Other appropriate disciplines as determined as requested by the comprehensive and quassessments.	care plan must be- days after completion of sessment. erdisciplinary team, that ited to sician. with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). The included in a resident's participation of the resentative is determined development of the staff or professionals in ned by the resident's needs the resident. ised by the interdisciplinary esment, including both the	F 2	280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER	1,001.10		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	04/2017
			7600 AUTUMN PARKWAY		
AUTUMN CARE OF MECHANICS	SVILLE		MECHANICSVILLE, VA 23116		
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F 280 Continued From pa	ge 43	F 28	0		
Based on observar document review a was determined that review and revise the for two of 27 resided Residents #14 and 1. The facility staff to comprehensive car condition related to #14. 2. For Resident #8, the comprehensive bilateral fall mats where the comprehensive bilateral fall mats where the comprehensive bilateral fall mats where the compession of the congestive heart far respiratory failure, the blood pressure, sle breathing while some chronic obstructive and atrial fibrillation contractions of the irregular beats of the heart output (2)). The most recent M assessment, a qual assessment referencesident as scoring interview for mental was cognitively intal	tion, staff interview, facility and clinical record review, it at the facility staff failed to the comprehensive care plan and the survey sample, #8. failed to review and revise the e plan with a change in a fractured ankle for Resident facility staff failed to revise care plan after an order for as discontinued on 4/27/17.	F 28	F 280 1. The Care Plans of Resident #8 were reviewed and updated to resident □s current needs at time survey. 2. All residents have the potent affected by this deficient practice 3. The Care Plan team and lice nurses were educated by the MD Coordinator on reviewing and revicomprehensive care plan. 4. The DON or designee will at plans 5 times a week for four were randomly weekly for eight weeks assure that care plans are updatichanges in resident condition. Reaudits will be taken to the QAPI committee monthly for 3 months review and revisions as needed. 5. Date of compliance: June 16	tial to be tial to be tensed OS vising the udit care eks, then to ed with esults of	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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	ROVIDER OR SUPPLIER CARE OF MECHANICS	VILLE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 AUTUMN PARKWAY 1/IECHANICSVILLE, VA 23116	, 00.02011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 280	The resident was ob 5/2/17 in her wheelch toed shoes on her feet. The resident was ob at 3:44 p.m. She had her feet. No surgical The comprehensive with a revised on dar part, "Focus: Fractur Healed per ortho (or (weight bearing as to documented in part, flat foot. Cam boot (sall times except for stated, 10/24/16 and documented in part, fracture to right ankle "Interventions" documented in part, fracture to right and counting all transfer and (every) shift." The carevised on 3/7/17, do Self-Care Deficit d/t coordination." The "I part, "Cast to right learn. When asked with the comprehensive of "The MDS team, ma	equiring only supervision after as provided for eating. served in the dining room on hair. She had black closed set. No surgical boot. served in her room on 5/3/17 d black closed toed shoes on boot. care plan dated, 10/25/16, te of 4/12/17, documented in set right ankle fracture. thopedist) on 4/11/17. WBAT olerated)." The "Interventions" "25% WT (weight) bearing surgical boot) to be worn at showers." The care plan revised on 3/20/17, "Focus: Altered skin integrity; et, incontinence." The mented in part, "1/24 (date) shoe for all transfers and Post-op shoe to be worn at standing activities Q are plan dated, 10/24/16 and ocumented in part, "Focus: (due to) COPD, Lack of interventions" documented in	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u> </u>	3010-412011
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F 280	Continued From pag	e 45	F 28	80		
	cast and a restricted documented on the changed the weight and the cast was rerbe updated to reflect stated, "Yes they shoon the care plan." The facility policy, "Cpart, "Policy: An intebe established for exaccordance with stat requirements and on must be measurable Coordinator is to rev for significant change ADL (activity of daily Planning Coordinator	asked if a resident has had a weight bearing status care plan, but the orthopedist bearing status to as tolerated noved, should the care plan these changes, RN #8 buld be marked as resolved are plan" documented in redisciplinary plan of care will very resident and updated in e and federal regulatory an as needed basisGoals and objectiveThe MDS item the 24 -hour Report daily the sor changes in resident's living) status. The Care re will add minor changes in the existing Care Plans on				
	Williams and Wilkins documented, "A writt communication tool a members that helps careThe nursing cainformation about the and goals. It contain achieving the goals and is used to direct revise and update the there are changes in with new orders" (3) Administrative staff radministrator, ASM #	en care plan serves as a among health care team ensure continuity of are plan is a vital source of e patient's problems, needs, as detailed instructions for established for the patient careexpect to review, e care plan regularly, when condition, treatments, and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/04/2017
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F 280	the above findings o	rdinator, were made aware of	F 28	0	
	Non-Medical Reader Chapman, page 45. (2) Barron's Dictiona Non-Medical Reader Chapman, page 55. (3) Fundamentals of	ry of Medical Terms for the 7,5th edition, Rothenberg and ry of Medical Terms for the 7,5th edition, Rothenberg and Nursing Lippincott Williams ncott Company Philadelphia			
	care plan after an ordiscontinued on 4/27 Resident #8 was addressed with diagnorm of limited to stroke, major depressive disparalytic gait and mumost recent MDS (magnetic particles) of 3/coded as being cogreto make daily decision the BIMS (Brief Interexam. Resident #8 wextensive assistance transfers, ambulation bathing; and indepersion of 5/4/17 at 11:00 at 10/18/15/15/15/15/15/15/15/15/15/15/15/15/15/	mitted to the facility on oses that included but were type two diabetes mellitus, order, anxiety disorder, ascle spasms. Resident #8's inimum data set) was a set with an ARD (assessment 17/17. Resident #8 was suitively impaired in the ability ons scoring 06 out of 15 on view for Mental Status) was coded as requiring a from one staff member with an dressing, hygiene, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 05/04/2017
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		00/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 280	made of Resident #1 no fall mats on the fill on 5/4/17 at 12:40 p made of Resident #1 no fall mats on the fill Review of Resident 10/18/16, with a revidocumented the followill have bilateral flointervention was init. Review of the most (a document for CN assistants) to use as documented the followill have bilateral floor in Review of Resident.	a.m., an observation was 3. She was lying in bed with oor. b.m., an observation was 3. She was lying in bed with oor. b.m., an observation was 3. She was lying in bed with oor. #8's fall care plan dated sed on date of 4/24/17 owing intervention: "Resident or mat while in bed." This inted on 3/14/17. recent Resident Care Guide As (certified nursing a reference) for Resident #8 owing: "SafetyResident will mats while in bed."	F 28			
	the following: "Bilater fallDiscontinue Date Dr. (doctor) order." On 5/4/17 at approximaterview was conducted who regularly works asked how CNAs we each resident in terriconal process of the unit." When a fall mats to the group #6 stated, "I haven't they were d/c'd (discontinuation).	ted 4/27/17 that documented and floor mats at bedtime for te/Reason: 4/27/17 2:04 p.m. imately 11:45 a.m., an acted with CNA # 6, a CNA with Resident #8. When build determine the needs of ans of safety interventions, can look at the care guides asked if Resident #8 needed and while she was in bed, CNA been seeing them. I think continued); even though the needs them. She gets up				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(C	X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER CARE OF MECHANICS	/ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	E	33/34/2017
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F 280	CNA #6 stated that s more harm than good responsible for upday stated that nursing upon when asked how and Resident #8 needed #6 stated, "I would go On 5/4/17 at 12:00 p conducted with LPN #14, Resident #8's in Resident #8 was supsafety intervention, Loneed an order for fall on the MAR (Medica or TAR (Treatment A #14 stated that becan Resident #8's MAR corder for fall mats. Would be updated if a orders to discontinue "Yes". When asked updating the care planurses or unit managupdating care plans, people can add interusually do it myself." was responsible for usually do it myself."	hever rings the call bell." he felt fall mats would do d. When asked who was ting the care guides, CNA #6 pdated the care guides. hew CNA would know if fall mats on the floor, CNA to ask the nurse." .m., an interview was (licensed practical nurse) urse. When asked if posed to have fall mats as a .PN #14 stated, "We would mats and fall mats are not tion Administration Record) dministration Record)." LPN use fall mats were not on or TAR then there was no then asked if the care plan a Resident received new e fall mats, LPN #14 stated, who was responsible for an, LPN #14 stated that the user was responsible for	F 2	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING				C 04/2017
	ROVIDER OR SUPPLIER			S 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY 1ECHANICSVILLE, VA 23116	1 03/	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280 F 281 SS=E	forgot to take it off the the ADL care plan. I just the ADL care member) #1, the adm (Director of Nursing) and increase were made away No further information ASM #2 stated the fareference for providing the fareference for providing the goals and information about the and goals. It contains achieving the goals eand is used to direct or revise and update the there are changes in with new orders" SERVICES PROVIDESTANDARDS CFR(s): 483.21(b)(3) (b)(3) Comprehensive as outlined by the commust-	e plan, RN #8 stated, "I e fall care plan. I took it off just missed it." n., ASM (administrative staff plantstrator, ASM #2, the DON and ASM #3, the corporate plants are of the above concerns. In was presented prior to exit. Collity uses Lippincott as a general plants of Nursing Lippincott 2007 pages 65-77 and care plants are versue continuity of the plants a vital source of patient's problems, needs, as detailed instructions for stablished for the patient careexpect to review, a care plant regularly, when condition, treatments, and the patient careexpect to review, a care plant regularly, when condition, treatments, and the patient care plants are plants and the patient care plants are plants.		280			5/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 05/04/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
AUTUMN	CARE OF MECHANICSV	ILLE		7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	N	
F 281	document review, and was determined that professional standard residents in the surve #3, and #14. 1. The facility staff fair of PRN (as needed) pure #8. 2. The facility staff fair standards of practice preparation/administr (registered nurse) #5 Resident #15's medication. 3. The facility staff fair for administration of Professional Facility staff fair for administration for Resident #15's medication for Resident #15's	n, staff interview, facility d clinical record review, it facility staff failed to follow its of practice for four of 27 by sample, Resident #8, #15, and to clarify the parameters pain medication for Resident for medication ation to Resident #15. RN failed to administer reation directly after preparing alled to clarify the parameters PRN (as needed) pain ent #3.	F 28	F 281 1. Resident s # 3 and #8 para for prn pain medication were cla MD. RN #5 was counseled on pand administering of medication Resident #14 s Tylenol order will clarified and is now current. 2. All residents have the poter affected by these deficient pract 3. The DON or designee will in all licensed nurses on Administer medications to include providing clarification for the administration medications, clarification on orcuse of Tylenol, and on administer medications directly after prepared. The DON/designee will audication physician sorders 5 times a weare weeks then weekly for 8 weeks. DON/designee will audit 4 medications are seen and the passes weekly for 4 weeks than for 8 weeks. Results of audits weeked to the QAPI committee mass amonths for review and revision needed. 5. Date of compliance: June 1	arified by preparing as. Intial to betices. In-service ering and of PRI ders for ering ration. If the cation a random will be onthly for as	e e N		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495413	B. WING		C 05/04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICS	SVILLE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/04/2017
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F 281	the BIMS (Brief Inte exam. Resident #8 extensive assistanc transfers, ambulatio bathing; and indeped Review of Resident Sheet) dated 4/1/17 following prn (as ne " "Norco Tablet [1 tablet by mouth expain. (This order was " Tylenol Tablet [Give 2 tablet by mo for pain. (This order Pain parameters cophysician orders dowhen each pain show the example of	#8's POS (Physician Order through 4/30/17 revealed the eded) orders: 1] 5-325 mg (milligrams) Give very four hours as needed for as initiated on 11/2/16). 2] 325 mg (acetaminophen) uth every 4 hours as needed was initiated on 11/9/16." uld not be found on the cumenting instructions to staff buld be administered. #8's April 2017 MAR estration Record) revealed that ad Norco and Tylenol on the times: at 7:16 p.m., 4/24/17 at 2:24	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 5/04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		0/04/2011
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 281	considers 1-3 mild particles anything over 6 as set that she will administ of 1-5. If the Tylenol stated that she would LPN #14 stated that it pain at a 6 or higher, the Norco. When assume exact process it medications without particles that she assumed off same process but was they considered to be pain or how they would medication to give. We the Norco and Tyleno parameters, LPN #14 should be clarified." On 5/4/17 at 9:10 a.m. conducted with RN (Funit Manager. When which pain medication Resident #8 is expering the pain is a 4 or lew would administer the other interventions has stated that she considered that she was when to give which milevel they considered severe. RN #8 stated stated that she was when to give which milevel they considered severe. RN #8 stated state	in. LPN #14 stated that she in, 5-6 moderate pain and evere pain. LPN #14 stated er Tylenol for pain at a level is ineffective, LPN #14 then administer the Norco. If the Resident rates their she would just administer sed if other nurses do the for administering pain parameters, LPN #14 stated are nurses would do the s not sure what numbers a mild, moderate or severe lid decide which pain when asked if the orders for all should have pain stated, "Yes. The orders a., an interview was Registered Nurse) #8, the asked how she determines	F 2	81		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/S			X3) DATE SURVEY COMPLETED		
	495413	B. WING _			C 05/04/2017
	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u>'</u>	0.000
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The facility Policy title Authorization and Corpharmacy" documen "3. Orders that may pharmacy from the esystem include the form 3.3.1 Orders with mission by law and regulation 3.3.2 Orders with missinformation6. Pharmacy may of telephone order before when the pharmacist to clarify the medicatis unclear, incomplet or has a drug-drug in 6.1 Facility staff shoum achine(s) for any personable for the pharmacy will her physician/Prescriber 6.3 Facility staff shour physician/Prescriber pharmacy of an orde 6.4 Facility should exphysician/Prescriber and document any needs. Facility staff shour esult and any new or pharmacy." On 5/4/17 at 1:52 p.r. member) #1, the adm (Director of Nursing) nurse were made aware systems with may be supported to the facility staff shour esult and any new or pharmacy."	ed, "4.1 Physician/Prescriber ommunication of Orders to ts in part, the following: y not be accepted by the lectronic medical record ollowing: sing diagnoses if required in the sesing stop dates (i.e. sesing or incomplete contact Facility staff via fax or the dispensing a medication in believes that there is a need ion order because the order the or vague, contraindicated, iteraction. In the lide to clarify the order, and contact the when staff is notified by it requiring clarification. It is able to clarify the order. In the issue to the document the clarification of the worders received." In the issue to the document the clarification of the communicate the reders or directions to the communicate the reders or directions to the communicate of the above concerns.	F 2	81		
[1] Norco is a narcoti	c pain reliever used to treat				
	CARE OF MECHANICSY SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page The facility Policy title Authorization and Co Pharmacy" documen "3. Orders that may pharmacy from the e system include the fo 3.3.1 Orders with mis by law and regulation 3.3.2 Orders with mis information6. Pharmacy may of telephone order befo when the pharmacist to clarify the medicat is unclear, incomplet or has a drug-drug in 6.1 Facility staff shou machine(s) for any p 6.2 Pharmacy will ho Physician/Prescriber 6.3 Facility staff shou Physician/Prescriber 6.4 Facility staff shou Physician/Prescriber and document any ne 6.5 Facility staff shou Physician/Prescriber and document any ne 6.5 Facility staff shou result and any new o Pharmacy." On 5/4/17 at 1:52 p.r member) #1, the adn (Director of Nursing) nurse were made aw No further information	A95413 ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 The facility Policy titled, "4.1 Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documents in part, the following: "3. Orders that may not be accepted by the pharmacy from the electronic medical record system include the following: 3.3.1 Orders with missing diagnoses if required by law and regulation. 3.3.2 Orders with missing stop dates (i.e. antibiotics); 3.3.3 Orders with missing or incomplete information6. Pharmacy may contact Facility staff via fax or telephone order before dispensing a medication when the pharmacist believes that there is a need to clarify the medication order because the order is unclear, incomplete or vague, contraindicated, or has a drug-drug interaction. 6.1 Facility staff should regularly check the fax machine(s) for any pharmacy communication. 6.2 Pharmacy will hold medication orders until Physician/Prescriber is able to clarify the order. 6.3 Facility staff should contact the Physician/Prescriber when staff is notified by pharmacy of an order requiring clarification. 6.4 Facility should explain the issue to the Physician/Prescriber document the clarification and document any new orders received." 6.5 Facility staff should then communicate the result and any new orders or directions to the	ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 The facility Policy titled, "4.1 Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documents in part, the following: "3. 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ROWIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPCIENCY MUST BE PRECEDED BY FULL REQUIR OF MECHANICSVILLE, VA 23116 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPCIENCY MUST BE PRECEDED BY FULL REQUIR DEPCIENCY OR LSC DENTIFY MO INFORMATION) Continued From page 53 The facility Policy titled, "4.1 Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documents in part, the following: "3. Orders hat may not be accepted by the pharmacy from the electronic medical record system include the following: "3. Orders with missing diagnoses if required by law and regulation. 3.3.1 Orders with missing stop dates (i.e. antibiotics); 3.3.3 Orders with missing or incomplete information 6. 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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		495413	B. WING _			C 5/04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u> </u>	5/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	National Institutes of https://www.ncbi.nlm. T0010590/?report=de [2] Tylenol (Acetamin aches and pains and information was obtal Institutes of Health. https://www.ncbi.nlm. T0008785/?report=de 2. Resident #15 was 3/29/17. Resident #1 were not limited to: di disease and muscle work most recent MDS (mi Medicare assessmen reference date) of 4/2 cognition as moderat comprehensive care failed to document intiming of medication padministration. On 5/2/17 at 5:05 p.n. RN (registered nurse medication cart in the RN #5's medication pwas only one person RN #5 told this surve and room number. RI cup that contained two medication cart. RN show you because I at though I probably sho compared the two pill two pharmacy labeled.	n was obtained from The Health. nih.gov/pubmedhealth/PMH etails ophen) is used to treat minor also reduces fever. This ned from The National nih.gov/pubmedhealth/PMH etails. admitted to the facility on 5's diagnoses included but abetes, chronic kidney weakness. Resident #15's nimum data set), a 30 day t with an ARD (assessment 26/17, coded the resident's ely impaired. Resident #15's plan initiated on 3/29/17 formation regarding the	F 2	81		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		495413	B. WING			C 05/04/2017
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F 281	Continued From pag	e 55	F 2	81		
	she had already prey medication and why #15's medication dire medication. RN #5 s fast." RN #5 was as be prepared and star give it to the patient. prepared Resident # was standing down to minutes before this s. On 5/3/17 at 5:42 p.r member) #1 (the addirector of nursing), of clinical services) at (the transitional care aware of the above f what standard of prastated the facility reference was a compared to the patients. Philadelphia, PA. Pa Administering Oral M. "Procedure: 1. Wash hands 2. Arrange MAR nex 3. Prepare medication time 4. Remove ordered in 5. Calculate correct of the correct of the correct of the correct of the prepare selected in the prepare selected in the correct of th	25. RN #5 was asked why bared Resident #15's she didn't prepare Resident ectly before administering the stated, "I was trying to be ked when medication should ted, "Right as I'm about to "RN #5 stated she had 15's medication while she he hall, approximately five surveyor approached her. m., ASM (administrative staff ministrator), ASM #2 (the ASM #3 (the regional director and RN (registered nurse) #3 coordinator) were made indings. ASM #2 was asked ctice the facility followed and erenced Lippincott. R Wilkins. 5th edition, ge 568, "Procedure 29-1; Medications" It to medication supply ons for only one client at a medications from supply drug dosage medications lirectly to client's room. Do a unattended."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING				C 04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	/ILLE		7600 A	TADDRESS, CITY, STATE, ZIP CODE UTUMN PARKWAY ANICSVILLE, VA 23116	1 00.	V 112V 1.
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	Preparation and Med documented, "3. Dos take all measures red Applicable Law, inclu following3.2 Facility medications for one red No further information." 3. Resident # 3 was red 03/11/17 with diagnoral not limited to: neuron cancer (1), gastroeso diabetes mellitus (3), hypertension (5), atric (7), and neuropathy (1). Resident # 3's most red set (1), a significant chance ARD (assessment red coded Resident # 3 a interview for mental set (1), nine being mode for making daily decisted as requiring extended for action. A review of the POS For Resident # 3 date (05/03/2017 document "Hydrocodone-Aceta MG (milligram) Give every 6 (six) hours as Date: 03/11/2017." "Give 2 (two) tablets to needed for pain. Order	r policy titled, "General Dose lication Administration" e preparation: Facility should quired by Facility policy and iding, but not limited to the resident at a time" In was presented prior to exit. The eadmitted to the facility on sees that included but were inuscular dysfunction of the ophageal reflux disease (2), anxiety (4), depression, al fibrillation (6), glaucoma (8). The ecent MDS (minimum data ange assessment with an inference date) of 03/16/17, as scoring a nine on the brief status (BIMS) of a score of 0 derately impaired of cognition is sions. Resident # 3 was extensive assistance of one vities of daily living. (Physician's Order Sheet) ed 04/03/2017 through	F	281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405442	B. WING				
NAME OF D	DOVIDED OD CLIDDLIED	495413	B. WING		STREET ADDRESS SITV STATE ZID CODE	05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	needed for pain. Ord The eMAR (electronic record) for Resident # documented the above March 2017 revealed - Hydrocodone-Aceta administered on 03/1; p.m., 03/13/17 at 10:3 a.m. and 11:12 a.m., 03/17/17 at 5:39 a.m. 12:02 p.m., 03/19/17 2:52 a.m. and 9:28 a. 03/22/17 at 8:58 p.m. a.m. - Hydrocodone-Ibuproadministered on 03/1; at 2:41 a.m. and 1:28 a.m., and on 03/31/17 - Tylenol 325 MG waat 1:46 a.m. and on 0 The eMAR (electronic record) for Resident # documented the above eMAR dated April 20′ - Hydrocodone-Aceta administered on 04/0 at 4:33 a.m., 04 04/17 9:31 a.m. and 04/05/7 9:25 a.m., 04/10/17 a a.m. and 9:00 a.m., 0 04/16/17 at 12:47 p.m. 19/17 at 3:20 a.m., 04/26/17 at 2:52 p.m., 04/26/17 a	mouth every 4 hours as er Date: 03/12/2017." c medication administration a dated "March 2017 re orders. The eMAR dated the following: aminophen 7.5-325 MG was 2/17 at 12:35 a.m. and 8:56 a3 p.m., 03/15/17 at 12:23 03/16/17 at 12:15 p.m., and 12:31 p.m., 03/20/17 at m., 03/21/17 at 11:17 a.m., and on 03/24/17 at 1:03 ofen 7.5-200 MG was 2/17 at 1:22 p.m., 03/14/17 p.m., 03/29/17 at 10:19 at 12:30 p.m. c medication administration a dated April 2017 re physician orders. The 17 revealed the following: aminophen 7.5-325 MG was 1/17 at 10:35 p.m., 04/03/17 at 9:44 a.m., 04/05/17 at 17 at 8:35 p.m., 04/07/17 at 19:37 a.m., 04/11/17 at 1:42	F	281			

AND BLAN OF CORRECTION IN IMPER-		LE CONSTRUCTION G		COMPLETED		
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	I	03/04/2017
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F 281	Continued From pa	ge 58	F 2	81		
	- Tylenol 325 MG w at 4:01 p.m.	as administered on 04/29/17				
	record) for Residen documented, "Hydrocoumented, "Hydrocoumented," Tablet (9) 7.5-325 Mount to the record tablet by mouth ever pain. Order Date: (April 2017 revealed Hydrocodone-Aceta administered on 05 The "Progress Note 03/11/2017 through and failed to eviden medications were continued to evidence padministration of Remedication of Hydrocometal The care plan for Remedication of Hydrocometal The C	aminophen 7.5-325 MG was /01/17 at 1:49 a.m. es" for Resident # 3 dated of 05/01/2017 were reviewed noe Resident # 3's PRN pain elarified.				
	On 05/03/17 at 1:20 conducted with LPN 5. When asked to administering PRN LPN # 5 stated, "I what type of pain, oscale one to ten, ba administer what is a the resident after 30 medication was effect was determined which should be administer."	D p.m. an interview was N (licensed practical nurse) # describe the procedure of (as needed) pain medication, would ask where the pain is, determine the level of pain on a ased on the level of pain would prescribed, I would reassess D minutes to see if the ective. When asked how it is lat PRN pain medication lered LPN # 5 stated, "If there leds (medications) there needs				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING				04/2047
	ROVIDER OR SUPPLIER			S 7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	05/0	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	there are no paramet from the physician be When asked to descriptions that the physician be when asked to descriptions. It would dependevel." After reviewing April and May 2017 a Resident # 3's PRN proceeding was asked if there was parameters. LPN # 5 parameters." On 05/03/17 at 1:40 procedured with RN (manager. When asked of administering PRN stated, "Do a pain assobserve nonverbal cuten, ten being most since what was ordered last got pain medication to determ effective using the pait is determined what be administered, RN them [resident] what prefer." On 05/03/17 at 2:00 proconducted with RN (manager. When asked of administering PRN stated, "Rate the residuated, "Rate the residuated in the residuated in the residuated, "Rate the residuated, "Rate the residuated, "Rate the residuated, ask where the	the physician's order. If ers I would get clarification for giving the medication." ibe parameters, LPN # 5 we one pain medication for moderate don the resident's pain g the eMARs dated March, and the physician's orders for the pain medications LPN # 5 as documentation of the stated, "There are no example of the procedure pain medication, RN # 6 as essment, location, intensity, the pain medication, intensity, the pain medication, and administer according to the procedure of the procedure pain medication, intensity, the pain medication intensity, the pain scale one to the procedure of the pro	F	281			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495413	B. WING			05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	is determined what Pl be administered, RN: parameters on the ph no parameters I would physician before givin reviewing the eMARs 2017 and the physicia 3's PRN pain medical there was documenta stated, "There are no On 05/04/17 at appro (administrative staff m administrator, and AS were made aware of the No further information References: 1. The uncontrolled g the body. Cancerous malignant cells. This from the website: https://medlineplus.go 2. Stomach contents the esophagus and in was obtained from the https://www.nlm.nih.g 3. A chronic disease i regulate the amount of information was obtai https://www.nlm.nih.g 001214.htm.	level." When asked how it RN pain medication should # 7 stated, "There should be sysician's order. If there are d get clarification from the nog the medication." After dated March, April and May an's orders for Resident # tions, RN # 7 was asked if ation of parameters. RN # 7 parameters." ximately 1:50 p.m. ASM nember) # 1 the SM # 2, director of nursing, the findings. In was provided prior to exit. rowth of abnormal cells in cells are also called information was obtained ov/ency/article/001289.htm.	F	281			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	L		7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u> 03/</u>	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 281	#summary. 5. High blood pressur obtained from the wel https://www.nlm.nih.g essure.html. 6. A problem with the heartbeat. This information the website: https://www.nlm.nih.gon.html. 7. A group of disease optic nerve. This information the website: https://www.nlm.nih.gon.html. 8. Nerve damage. The from the website: https://www.google.com/linearte-ingredients, and products are prescrib hydrocodone combinate relieve moderate-to-shydrocodone combinate relieve cough. Hydrocodone called op and in a class of medications called op and in a class of medications.	ov/medlineplus/anxiety.html e. This information was besite: ov/medlineplus/highbloodpr speed or rhythm of the mation was obtained from ov/medlineplus/atrialfibrillati s that can damage the eye's rmation was obtained from ov/medlineplus/glaucoma.ht ov/medlineplus/glaucoma.ht his information was obtained om/#q=neuropathy+nih. ailable in combination with different combination ed for different uses. Some ation products are used to	F	281	DETIGENOT)		
	the brain and nervous This information was	s system respond to pain. obtained from the website: ov/druginfo/meds/a601006.h					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		495413	B. WING				0
	ROVIDER OR SUPPLIER		D. W	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	05/0	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D BE COMPLETION	
F 281	moderate pain from hemenstrual periods, cotoothaches, backache vaccinations (shots), Acetaminophen may pain of osteoarthritis (breakdown of the lining Acetaminophen is in an analgesics (pain relied reducers). It works by senses pain and by conformation was obtain https://medlineplus.gottml. 4. The facility staff fair physician order for Typrescribed for fever to could also be administed. Resident #14 was add 10/24/16 with a readd diagnoses included be congestive heart faillurespiratory failure, frablood pressure, sleep breathing while some chronic obstructive puand atrial fibrillation (recontractions of the atrirregular beats of the heart output (2)).	Used to relieve mild to readaches, muscle aches, olds and sore throats, es, and reactions to and to reduce fever. also be used to relieve the (arthritis caused by the ng of the joints). a class of medications called vers) and antipyretics (fever or changing the way the body cooling the body. This ned from the website: https: by/druginfo/meds/a681004.ht. Iled to clarify Resident #14's relend which the physician of determine if the medication stered for pain. Imitted to the facility on mission on 11/21/16. Her ut were not limited to: re (CHF), acute and chronic cture of the lower leg, high or apnea (periods of not one sleeps (1)), anemia, ulmonary disease (COPD), rapid and random ria of the heart causing ventricles decreasing the	F	281			
	assessment reference	erly assessment, with an e date of 3/14/17, coded the 14 on the BIMS (brief					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
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	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	00/04/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 281	was cognitively inta The resident was co assistance for most She was coded as set up assistance w The physician orde "Tylenol Tablet 325 by mouth every 8 h The February 2017 administration reco Tablet 325 MG; Giv hours as needed fo documented the res 2/21/17 at 9:04 a.m documented. Revie reveal documentati Review of the vital s record did not reveal had a fever. The April 2017 MAR 325 MG; Give 2 tab needed for Fever." resident received T p.m. for a pain leve notes did not revea Resident #14. Rev the clinical record d resident had a feve The May 2017 MAR 325 MG; Give 2 tab needed for Fever." resident received T p.m. for a pain leve notes did not revea Resident #14. Rev the clinical record d resident received T going Give 2 tab needed for Fever." resident received T for a documented p	status) score, indicating she ct to make daily decisions. oded as requiring extensive of her activities of daily living. requiring only supervision after ras provided for eating. In dated, 1/1/17, documented, MG (milligrams); Give 2 tablet ours as needed for Fever." MAR (medication red) documented, "Tylenol ee 2 tablet by mouth every 6 or Fever." The MAR sident received Tylenol on and a pain level of "6" was we of the nurse's notes did not on of a fever for Resident #14. Signs section of the clinical all any evidence the resident R documented, "Tylenol Tablet let by mouth every 6 hours as The MAR documented the ylenol on 4/28/17 at 12:10 of "6." Review of the nurse's a documentation of a fever for iew of the vital signs section of iid not reveal any evidence the	F 28		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495413	B. WING		C 05/04/2017
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 281	signs section of the cany evidence the resonany evidence the resonant evidence the reson	#14. Review of the vital dinical record did not reveal ident had a fever. care plan dated, 10/24/16, is. ducted with LPN (licensed on 5/3/17 at 3:10 p.m. The above was reviewed with dif the nurse could give the ed on the above order, LPN would have to get a whole diducted with LPN #10, the language with LPN #10. It is reviewed with LPN #10 this order, it should only be above order, LPN #10 this order, it should only be an asked what the nurse stated, "They need to clarify a new order for Tylenol for " hysician/Prescriber of the munication of Orders to ted in part, "8.1 Facility's all did contact the resident' when there is a change in quire a new medication or a	F 28	31	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495413	B. WING				C 04/2017
	ROVIDER OR SUPPLIER	ILLE	•	76	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281 F 282 SS=E	(1) Barron's Dictionar Non-Medical Reader, Chapman, page 45. (2) Barron's Dictiona Non-Medical Reader, Chapman, page 55.	n was provided prior to exit. y of Medical Terms for the 5th edition, Rothenberg and ry of Medical Terms for the 5th edition, Rothenberg and LIFIED PERSONS/PER		281			5/30/17
	as outlined by the cormust- (ii) Be provided by quaccordance with each care. This REQUIREMENT by: Based on staff interviacility document revireview, it was determ failed to follow the wr 27 residents in the suffailed, #7, #3, and #8. 1. a. The facility staff nursing services per the Resident #14 b. The facility staff failed.	d or arranged by the facility, imprehensive care plan, alified persons in a resident's written plan of is not met as evidenced iew, resident interview,			F282 1. Resident #14 s change in weight reported to the physician. Resident #1 currently receiving skilled therapy. If appropriate, Resident #14 will resume restorative care after skilled therapy en The physician was notified of staff failu to obtain blood pressure for resident #7 Resident #8 discharged from the facility 5/9/17. The physician was informed of staff stallure to document Resident #3 blood pressure weekly. 2. All residents have the potential to laffected by these deficient practices.	4 is ds. re 7. y f	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495413	B. WING			05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	/ILLE		76	TREET ADDRESS, CITY, STATE, ZIP CODE 500 AUTUMN PARKWAY ECHANICSVILLE, VA 23116	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Resident #7. 3. The facility staff fair comprehensive care 4. The facility staff fair non-pharmacological administration of PRN Resident #8's written The findings include: 1. a. Resident #14 wa 10/24/16 with a readr diagnoses included be congestive heart failurespiratory failure, frablood pressure, sleep breathing while some chronic obstructive prand atrial fibrillation (contractions of the at irregular beats of the heart output) (2). The most recent MDS assessment, a quarter assessment reference resident as scoring a interview for mental swas cognitively intact. The resident was cognitively intact.	iled to obtain a blood of the written plan of care for alled to follow Resident # 3's plan for pain. iled to attempt interventions prior to the N pain medications per plan of care. as admitted to the facility on mission on 11/21/16. Her put were not limited to: are (CHF), acute and chronic acture of the lower leg, high or apnea (periods of not be seeps) (1), anemia, allmonary disease (COPD), rapid and random ria of the heart causing ventricles decreasing the	F:	282	3. Director of Nursing or designee w in-service licensed nurses on non-pharmacological interventions, assessing to determine which pain medication should be administered whethere are choices of pain medications; documenting weights and blood pressurs ordered by physicians, and reporting the physician when values are outside stated parameters. The MDS coordinator designee will in-service CNAs on providing restorative care. 4. The Unit Managers or designees waudit the documentation of non-pharmacological interventions before the administration of pain medication; Unit Managers will audit blood pressur and weight documentation as ordered liphysician, and the reporting of variance as ordered. The Unit Managers or designees will audit the documentation restorative care to indicated residents. Audits will be conducted five times were for four weeks, then randomly weekly feight weeks. Audits will be reviewed by the QAPI committee for three months. 5. Date of completion: June 16, 2017	en ires g to of ttor vill ore e oy es of ekly or	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
		495413	B. WING			C 05/04/2017
	ROVIDER OR SUPPLIER	/ILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		03/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	The comprehensive documented in part, for ambulation related device, unsteady ball documented in part, plan. Resident will p 6/7 days a week." An interview was cor 5/3/17 at 3:44 p.m. For today (5/3/17) was the had been walked with Resident #14 stated, day, which is what the She gets pulled off reas a CNA (certified in An interview was cornurse) #2, the MDS in When asked who own ursing program, RN asked if a physician or restorative nursing, Faware of." RN #2 was documentation evide restorative program. On 5/3/17 at 5:14 p.r. "Restorative Ambulate for April 2017 for Resing Problem/Need" documentations" documentations" documentations documentations documentations documentations assistance (minutes); 6-7 days/wwalker, ambulate 50	care plan dated, 4/4/17, "Focus: Requires assistance d to: Requires assistive ance." The "Interventions" "Ambulation per restorative ractice 15 minutes a day for ducted with Resident #14 on Resident #14 stated that he first day in weeks that she in the restorative aide. "They can't walk me every restorative to work on the floor fursing assistant)." Inducted with RN (registered for the restorative to work on the floor furse, on 5/3/17 at 4:40 p.m. resees the restorative #2 stated, "I do." When forder was required for RN #2 stated, "Not that I'm is asked to provide any form Resident #14 was in a more responsible to bold the floor program Daily Record" for the floor program Daily Record for RN #2 presented the floor program Daily Record for RN #2 presented the floor program Daily Record for the floor program Daily Record for the floor part, "15 min week, device needed feet.	F 28	32		
	The "Restorative Am	bulation Program" dated for				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	· /	ATE SURVEY OMPLETED
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1	33/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	April 2017 document restorative ambulatio days: The week of April 2 - received restorative rower The week of April 9 - received restorative rower The week of April 16 not receive any restorative rower The week of April 23 received restorative rower An interview was con at 5:14 p.m. When as receiving the restorative When asked if some #2 stated, "Yes." When program for restorative When asked if some #2 stated, "Yes." When program for restorative followed, RN #2 stated. An interview was commanager, on 5/4/17 at the purpose of the cathe guidance we are be taken to care for athe care plan should "Yes, Ma'am." The facility policy, "C part, "All direct care sunderstand and follow If unable to implement your Charge Nurse of this can be documen changed if necessary	ed the resident received in program on the following 8, 2017, the resident foursing on five days. 15, 2017, the resident foursing on four days. 22, 2017, the resident foursing on four days. 29, 2017, the resident foursing on six days. 29, 2017, the resident foursing on six days. 20017, the resident foursing on six days. 20017, the resident is not give nursing program per her stated, "We've had times for a like of the floor." 2001 one else should cover, RN and asked if a resident has a fixe care, should it be ed, "Yes." 2001 of action to the floor of a resident. When asked if the followed, RN #8 stated, "It's given and a plan of action to the followed, RN #8 stated, are Plan" documented in staff must always know, we their Resident's Care Plan. The following of the plan, notify in MDS Coordinator, so that the dor the Care Plan	F 2	82		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495413	B. WING				04/2047
	ROVIDER OR SUPPLIER		1	s 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY 1ECHANICSVILLE, VA 23116	[05/	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 282	communication tool a members that helps of careThe nursing care information about the and goals. It contains achieving the goals erand is used to direct of Administrative staff madministrator, ASM #ASM #3, the corporate transitional care coord the above findings on No further information (1) Barron's Dictionar Non-Medical Reader, Chapman, page 45. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 55. b. The facility staff fair a change in weight, president #14. The comprehensive of with a revised on date part, "Focus: Risk for intake characterized I skin and mucous merand integrity related to "Interventions" documents of the comprehensive o	2007 pages 65-77 en care plan serves as a mong health care team ensure continuity of re plan is a vital source of patient's problems, needs, a detailed instructions for stablished for the patient care. Dember (ASM) #1, the 2, the director of nursing, re nurse and RN #3 the dinator, were made aware of 15/3/17 at 5:35 p.m. In was provided prior to exit. By of Medical Terms for the 5th edition, Rothenberg and ry of Medical Terms for the 5th edition, Rothenberg and return the plan of care, for er the plan of care, for the plan of care, for the plan of care, for the correct of the plan of care, for the plan of	F	282			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		FE SURVEY MPLETED
		495413	B. WING _			C 5/04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		0/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 282	for monitoring. If there (pounds) in one day of MD (medical doctor). The MAR (medication February 2017 documented and for more time a day for more time a day for more time a day for more time and for more time.	ated, 11/21/16, weight daily; one time a day e is a weight gain of 2 lbs. or 5 lbs. in one week, notify	F 2			
	pounds. The April 2017 MAR of daily; one time a day weight gain of 2 lbs. in week, notify MD." The were documented: 4/3/17 - 252.8; 4/4/17 pounds.	documented, "Obtain eight for monitoring. If there is a none day or 5 lbs. in one e following weight gains - 256.4, a gain of 3.6 258, a gain of 2 pounds.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	.Υ
		495413	B. WING		05/04/20	17
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		<u>., </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	(X5) PLETION PATE
F 282	Continued From page 71 The above order was discontinued on 4/20/17.			32		
	Review of the nurse's notes from 2/1/17 through 4/20/17 did not evidence any documentation of the physician being notified of the weight gain. An interview was conducted with LPN (licensed practical nurse) #4 on 5/3/17 at 3:10 p.m. The above daily weight order was reviewed with her. When asked what is expected of the nurse with the above order, LPN #4 stated, "We have to weigh the person every day and call the doctor according to the order." When asked where that would be documented, LPN #4 stated, "It's					
	practical nurse) #4 of above daily weight of When asked what is the above order, LP weigh the person evaccording to the ord would be document documented in the plook." When asked of the clinical record	on 5/3/17 at 3:10 p.m. The order was reviewed with her. s expected of the nurse with N #4 stated, "We have to very day and call the doctor ler." When asked where that				
	conducted with LPN #10 was asked to re weights. LPN #10 w the nurse's respons "They have to weighthe doctor if the wei in a day or five pour where this notification	Im., an interview was I #10, the unit manager. LPN eview the above order for daily was then asked to explain what ibility is, LPN #10 stated, in the resident daily and notify ght is more than two pounds ands in a week." When asked on is documented, LPN #10 in a nurse progress note to tor was notified."				
	manager, on 5/4/17 the purpose of the of the guidance we are be taken to care for the care plan should "Yes, Ma'am." When	anducted with RN #8, a unit at 10:25 a.m. When asked are plan, RN #8 stated, "It's e given and a plan of action to a resident." When asked if d be followed, RN #8 stated, a asked if the physician orders of care, RN #8 stated,				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 05/04/2017	
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		00/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	administrator, ASM ASM #3, the corpor transitional care coordine above findings of the sacral region bony prominence repressure to the area dementia. The most recent MI assessment, a qual assessment referer resident as scoring interview for menta she was severely in daily decisions. Resident as for a living. The comprehensive	member (ASM) #1, the #2, the director of nursing, ate nurse and RN #3 the ordinator, were made aware of on 5/3/17 at 5:35 p.m. on was provided prior to exit. Failed to obtain a blood to the written plan of care for dimitted to the facility on 1/7/15 included but were not limited lood pressure, depression, desophageal reflux disease, and count (1)), pressure ulcer (inflammation or sore over a resulting from prolonged at (2)), dysphagia, and OS (minimum data set) the date of 2/3/17, coded the a zero on the BIMS (brief a status) score, indicating that inpaired to make cognitive sident #7 was coded as assistance of one or more II of her activities of daily	F2	82			
	with a revised on da	ate of 2/27/17, documented in discretized details at the desired desired details.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495413	B. WING		05/04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICS	VILLE	7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 282	disease) (any abnormal vessels outside the half of aorta (common displaques consisting mipids form on the innex of the half of aorta (common displaques consisting mipids form on the innex of the mark). The physician order "Weekly B/P (blood processure) of the mark of th	VD (peripheral vascular mal condition affecting blood heart) (3) and Atherosclerosis sorder of the arteries in which hostly of cholesterol and her arterial/aortic wall leading flow) (4)." The "Interventions" "Assess vital signs." dated, 4/28/16, documented, pressure) check one time a saday) for HTN (hypertension e)." on administration record) for ted, "Weekly B/P check one of the for HTN." The MAR amark and the nurse's initials e/20/17 and 4/27/17. There on of the blood pressures on the blood pressure taken on 4/4/17 at e's note dated, 4/12/17 at coument a blood pressure. E's notes dated 4/20/17 or signs" tab in the electronic umented no blood pressure. On 4/20/17 the blood hented as, "0/0 mmHg ary)." There was a blood homHg documented on	F 282		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495413	B. WING _		_	C 05/04/2017	
	ILLE		7600 AUTUMN PARKWAY		03/04/2017	
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asked what staff show written an order for a every Thursday, LPN should check the blood Thursday." When ask pressure reading wou stated, "It's in the elect note or in the vital sign of the vital signs that was review stated, "It's not there, the system correctly." An interview was con manager, on 5/4/17 at the purpose of the cast the guidance we are the taken to care for a the care plan should "Yes, Ma'am." When are part of the written "Absolutely." Administrative staff madministrator, and AS nursing, were made a on 5/4/17 at 2:52 p.m.	ald do if the physician has blood pressure to be taken #5 stated, "The nurse of pressure every ted where the blood ald be documented, LPN #5 ctronic record in a progress ans tab in the computer." ducted with LPN #10, the 117 at 3:18 p.m. When asked if the physician has written pressure to be taken every tated, the blood pressure R. Technically, it should not ted on unless the blood erted." The MAR and vital ed with LPN #10. LPN #10. The order was not put into 1. ducted with RN #8, a unit at 10:25 a.m. When asked re plan, RN #8 stated, "It's given and a plan of action to 1. ducted with RN #8 stated, "It's given and a plan of action to 1. ducted with RN #8 stated, "It's given and a plan of action to 1. ducted with RN #8 stated, "It's given and a plan of action to 1. ducted with RN #8 stated, "It's given and a plan of action to 1. ducted with RN #8 stated, "It's given and a plan of action to 1. ducted with RN #8 stated, "It's given and a plan of action to 1. ducted with RN #8 stated, "It's given and a plan of action to 1.	F 2	282			
(1) Barron's Dictionar	y of Medical Terms for the					
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page asked what staff show written an order for a every Thursday, LPN should check the blood Thursday." When ask pressure reading wow stated, "It's in the elect note or in the vital sign of the vital signs that was reviewed stated, "It's not there, the system correctly." An interview was commanager, on 5/4/17 at the purpose of the cate plan should "Yes, Ma'am." When are part of the written "Absolutely." Administrative staff madministrator, and As nursing, were made at on 5/4/17 at 2:52 p.m. No further information	A95413 ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #5 stated, "The nurse should check the blood pressure every Thursday." When asked where the blood pressure reading would be documented, LPN #5 stated, "It's in the electronic record in a progress note or in the vital signs tab in the computer." An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:18 p.m. When asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #10 stated, the blood pressure should be on the MAR. Technically, it should not be allowed to be charted on unless the blood pressure value is inserted." The MAR and vital signs tab was reviewed with LPN #10. LPN #10 stated, "It's not there. The order was not put into the system correctly." An interview was conducted with RN #8, a unit manager, on 5/4/17 at 10:25 a.m. When asked the purpose of the care plan, RN #8 stated, "It's the guidance we are given and a plan of action to be taken to care for a resident." When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated,	ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #5 stated, "The nurse should check the blood pressure every Thursday." When asked where the blood pressure reading would be documented, LPN #5 stated, "It's in the electronic record in a progress note or in the vital signs tab in the computer." An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:18 p.m. When asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #10 stated, the blood pressure should be on the MAR. Technically, it should not be allowed to be charted on unless the blood pressure value is inserted." The MAR and vital signs tab was reviewed with LPN #10. LPN #10 stated, "It's not there. The order was not put into the system correctly." An interview was conducted with RN #8, a unit manager, on 5/4/17 at 10:25 a.m. When asked the purpose of the care plan, RN #8 stated, "It's the guidance we are given and a plan of action to be taken to care for a resident." When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Absolutely." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 5/4/17 at 2:52 p.m. No further information was provided prior to exit.	ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 74 asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #5 stated, "The nurse should check the blood pressure very Thursday," When asked where the blood pressure reading would be documented, LPN #5 stated, "It's in the electronic record in a progress note or in the vital signs tab in the computer." 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When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am." When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am." When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Absolutely." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 5/4/17 at 2:52 p.m. No further information was provided prior to exit.	A BUILDING A BUILDING B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116 SUMMARY STATEMENT OF DEPICIENCIES SUMMARY STATEMENT OF DEPICIENCIES SUMMARY STATEMENT OF DEPICIENCIES (EACH OFFICIENCY WISS TE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) Continued From page 74 asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #5 stated, "The nurse should check the blood pressure every Thursday," When asked where the blood pressure or in the vital signs tab in the computer." An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:18 p.m. When asked what staff should be on the MAR. Technically, it should not be allowed to be charted on unless the blood pressure value is inserted. "The MAR and vital signs tab was reviewed with LPN #10, LPN #10 stated," It's not there. The order was not put into the system correctly." An interview was conducted with RN #8, a unit manager, on 5/4/17 at 10:25 a.m. When asked the purpose of the care plan ,RN #8 stated, "It's the guidance we are given and a plan of action to be taken to care for a resident." When asked if the care plan should be followed, RN #8 stated, "Yes, Malam." When asked if the care plan should be followed, RN #8 stated, "Yes, Malam." When asked if the care plan should be followed, RN #8 stated, "Yes, Malam." When asked if the dear plan and ASM #2, the director of nursing, were made aware of the above concern on 5/4/17 at 2:52 p.m. No further information was provided prior to exit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING	B WING			04/2047
NAME OF PR	ROVIDER OR SUPPLIER	400410		S	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	04/2017
AUTUMN	CARE OF MECHANICSV	ILLE			600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Non-Medical Reader, Chapman, page 33. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 155. (3) Barron's Dictiona Non-Medical Reader, Chapman, page 447. (4) Barron's Dictiona	5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and ry of Medical Terms for the 5th edition, Rothenberg and ry of Medical Terms for the 5th edition, Rothenberg and	F	282			
	comprehensive care pharcological interver pharcological interver Resident # 3 was rea 03/11/17 with diagnos not limited to: neurom cancer (1), gastroeso diabetes mellitus (3), hypertension (5), atria (7), and neuropathy (6). Resident # 3's most metal, a significant cha ARD (assessment ref coded Resident # 3 a interview for mental s - 15, nine being mode for making daily decis coded as requiring ex staff member for activity	dmitted to the facility on ses that included but were nuscular dysfunction of the phageal reflux disease (2), anxiety (4), depression, al fibrillation (6), glaucoma 8). ecent MDS (minimum data nge assessment with an ference date) of 03/16/17, s scoring a nine on the brief tatus (BIMS) of a score of 0 erately impaired of cognition sions. Resident # 3 was tensive assistance of one vities of daily living.					
	The POS (Physician'	s Order Sheet) For Resident					

` ′		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495413	B. WING		C 05/04/2017
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 33/04/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 282	# 3 dated 04/03/201 documented, "Hydro Tablet (9) 7.5-325 M tablet by mouth eve pain. Order Date: 0 Tablet 325 MG. Givevery 12 hours as n 03/11/2017." "Hydro 7.5-200 MG. Give 14 hours as needed for 03/12/2017." The eMAR (electron record) for Resident documented, "Hydro Tablet (9) 7.5-325 M tablet by mouth eve pain. Order Date: 0 Tablet 325 MG. Givevery 12 hours as n 03/11/2017." "Hydro 7.5-200 MG. Give 14 hours as needed for 03/12/2017." The eMAR dated Me Hydrocodone-Aceta administered on 03/ p.m., 03/13/17 at 10 a.m. and 11:12 a.m. 03/17/17 at 5:39 a.m. 12:02 p.m., 03/19/11/2:52 a.m. and 9:28 a 03/22/17 at 8:58 p.m. a.m.	7 through 05/03/2017 prodone-Acetaminophen IG (milligram) Give 1 (one) ry 6 (six) hours as needed for 3/11/2017." "Tylenol (10) e 2 (two) tablets by mouth eeded for pain. Order Date: codone-Ibuprofen Tablet (9) (one) tablet by mouth every for pain. Order Date: sic medication administration # 3 dated "March 2017 prodone-Acetaminophen IG (milligram) Give 1 (one) ry 6 (six) hours as needed for 3/11/2017." "Tylenol (10) e 2 (two) tablets by mouth eeded for pain. Order Date: codone-Ibuprofen Tablet (9) (one) tablet by mouth every for pain. Order Date:	F 28		
		8 p.m., 03/29/17 at 10:19			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	C	(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 05/04/2017	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, Z 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		33/34/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE	
F 282	1:46 a.m. and on 03/ The eMAR (electroni record) for Resident documented, "Hydror Tablet (9) 7.5-325 MG tablet by mouth every pain. Order Date: 03 Tablet 325 MG. Give every 12 hours as ne 03/11/2017." The eMAR dated Apr "Hydrocodone-Aceta administered on 04/0 at 4:33 a.m., 04 04/1 9:31 a.m. and 04/05/9:25 a.m., 04/10/17 a.m. and 9:00 a.m., 0 04/16/17 at 12:47 p.r 19/17 at 3:20 a.m., 0 2:52 p.m., 04/26/17 a.m., 04/29/17 at 1:0	7 at 12:30 p.m. administered on 03/12/17 at 16/17 at 11:27 a.m. c medication administration # 3 dated April 2017 codone-Acetaminophen G (milligram) Give 1 (one) y 6 (six) hours as needed for 11/2017." "Tylenol (10) e 2 (two) tablets by mouth reded for pain. Order Date:	F 2		ENCY)		
	record) for Resident adocumented, "Hydror Tablet (9) 7.5-325 MG tablet by mouth even pain. Order Date: 03	c medication administration # 3 dated May 2017 codone-Acetaminophen G (milligram) Give 1 (one) y 6 (six) hours as needed for s/11/2017." ril 2017 revealed, minophen 7.5-325 MG was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	Continued From page	e 78	F 2	82		
	03/11/2017 through 0 and failed to evidence non-pharmacological administration of Hyd Hydrocodone-Acetan The care plan for Res documented, "Focus: Neuropathy, Glaucon 03/24/2016. Revision "Interventions" it documen-pharmacological Date Initiated: 04/11/2	interventions prior to the rocodone-Ibuprofen, ninophen and Tylenol. sident # 3 dated 07/12/16 Pain related to Arthritis, na. Date Initiated: n on 01/19/2017." Under umented, "Staff to offer interventions as tolerated.				
	conducted with LPN of 5. When asked to de administering PRN (a LPN # 5 stated, "I wo what type of pain, de scale one to ten, bas would administer what reassess the resident the medication was edescribe the purpose stated, "It tells you have resident." After revie Resident # 3's pain, Lare plan was followed interventions. LPN # On 05/03/17 at 1:40 pronducted with RN (manager. When ask of administering PRN stated, "Do a pain as	(licensed practical nurse) # escribe the procedure of as needed) pain medication uld ask where the pain is, termine the level of pain on a ed on the level of pain, I at is prescribed, I would t after 30 minutes to see if effective. When asked to of the care plan, LPN # 5 ow to take care of the wing the care plan for LPN # 5 was asked if the ed for non-pharmacological				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 5/04/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		5/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	see what was ordered last got pain medication to the physician's ord 30 to 60 minutes after determine if it was eff. When asked to describle plan, RN # 6 stated, "interventions are in president's needs are atto take care of them was reviewing the care plan RN # 6 was asked if the for non-pharmacologistated, "No, it wasn't." On 05/03/17 at 2:00 president was asked if the pain medication according to the pain describe the purpose stated, "It shows what of all the care for the plan it needs to be for care plan for Resident asked if the care plan non-pharmacological stated, "No, it wasn't." On 05/04/17 at approximation administrator, and AS were made aware of	evere. Check the order to d, check to see when they on and administer according er, follow-up approximately r giving the medication to fective using the pain scale." libe the purpose of the care at tells you what lace. It tells what the land what we are going to do while they are here." After an for Resident # 3's pain, the care plan was followed ical interventions. RN # 6 followed for pain." o.m. an interview was egistered nurse) # 7, unit ed to describe the procedure pain medication RN # 7 dent's pain on a scale of one pain is and to describe it. should be administered level." When asked to of the care plan, RN # 7 t we're doing, a description resident. If it's on the care llowed." After reviewing the at # 3's pain, RN # 7 was a was followed for interventions. RN # 7 followed." eximately 1:50 p.m. ASM nember) # 1 the SM # 2, director of nursing,	F 28	32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		495413	B. WING	B. WING			04/2047
	ROVIDER OR SUPPLIER	l		7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u> US/</u>	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page	e 80	F	282			
	the body. Cancerous malignant cells. This from the website: https://medlineplus.gd 2. Stomach contents the esophagus and ir was obtained from the https://www.nlm.nih.gd 3. A chronic disease is regulate the amount of information was obtain https://www.nlm.nih.gd 001214.htm. 4. Fear. This information website: https://www.nlm.nih.gd #summary. 5. High blood pressur obtained from the wehttps://www.nlm.nih.gd essure.html. 6. A problem with the heartbeat. This information with the heartbeat. This information with the heartbeat. This information website: https://www.nlm.nih.gd on.html.	information was obtained by/ency/article/001289.htm. to leak back, or reflux, into ritate it. This information e website: hov/medlineplus/gerd.html. In which the body cannot of sugar in the blood. This ned from the website: hov/medlineplus/ency/article/ Ition was obtained from the hov/medlineplus/anxiety.html					

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		495413	B. WING			C 5/04/2017	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		1 00/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282	https://www.nlm.nih.ml. 8. Nerve damage. T from the website: https://www.google.co. 9. Hydrocodone is an other ingredients, an products are prescril hydrocodone combir relieve moderate-to-hydrocodone combir relieve cough. Hydrocodone relieve cough. Hydrocodone relieve the brain and nervou This information was https://medlineplus.gtml. 10. (Acetaminophen moderate pain from menstrual periods, cotothaches, backach vaccinations (shots), Acetaminophen may pain of osteoarthritis breakdown of the line Acetaminophen is in analgesics (pain reliereducers). It works be senses pain and by information was obtained.	gov/medlineplus/glaucoma.ht This information was obtained com/#q=neuropathy+nih. vailable in combination with did different combination bed for different uses. Some nation products are used to severe pain. Other nation products are used to codone is in a class of piate (narcotic) analgesics dications called antitussives. es pain by changing the way as system respond to pain. sobtained from the website: gov/druginfo/meds/a601006.h) Used to relieve mild to headaches, muscle aches, olds and sore throats, nes, and reactions to and to reduce fever. valso be used to relieve the (arthritis caused by the	F 28	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495413	B. WING		05/04/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICS	/ILLE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 282	Continued From pag	e 82	F 282			
	administration of PRI Resident #8's plan of	interventions prior to the N pain medications per				
	10/18/16 with diagno not limited to stroke, major depressive dis paralytic gait and mu	ses that included but were type two diabetes mellitus, order, anxiety disorder, scle spasms. Resident #8's inimum data set) was a				
	reference date) of 3/coded as being cogn to make daily decision	t with an ARD (assessment 17/17. Resident #8 was itively impaired in the ability ins scoring 06 out of 15 on view for Mental Status)				
	exam. Resident #8 w extensive assistance	ras coded requiring as from one staff member with dressing, hygiene, and				
	Sheet) dated 4/1/17 following prn (as nee "Norco Tablet [1] 5-3.	#8's POS (Physician Order through 4/30/17 revealed the ded) orders: 25 mg (milligrams) Give 1 y four hours as needed for				
	Tylenol Tablet [2] 325	5 mg (acetaminophen) Give 2 y 4 hours as needed for				
	Resident #8 received following dates and t	ration Record) revealed that I Norco and Tylenol on the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP C 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	ODE	33,54,2311
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	· ·	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	There was no evider non-pharmacologica attempted prior to the and Tylenol to Resident: 10/18/16 and update following: "Pain d/t (opolyneuropathy, and maintain comfort to Interventions: Staff non-pharmacological Con 5/4/17 at 8:29 a.r. conducted with LPN #14, a nurse who ad medication on 4/27/1 asked the process stadministering a pring stated that she would to see if they really in then she would ask to LPN #14 stated that speak she would loo such as facial express she will always attentinterventions prior to medication. When a non-pharmacological would be documented.	ince in the clinical record that I interventions were end administration of the Norco ent #8 on the dates above. #8's Pain care plan dated and 3/10/17 documented the due to) limited mobility, falls, muscle spasmGoal: Will highest degrees possible. If to attempt I interventions as tolerated." m., an interview was (licensed practical nurse) ministered prn pain 17 to Resident #8. When the taff follows prior to pain medication, LPN #14 and first calm the resident down needed the medication and the resident to rate their pain. For residents who cannot was at the taff that non-verbal cues for pain assions. LPN #14 stated that anon-pharmacological administering pain	F2	282		
	on 4/27/17, LPN #14 MAR and stated, "Ye non-pharmacologica	tered Tylenol to Resident #8 Flooked at the initials on the es." When asked where I interventions were 14 stated, "She requested it. I				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		LE CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 05/04/2017		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	'	03/04/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 282	think she said her sh	noulder was hurting. I think I	F 28	2				
	to try to a warm com	n her the Tylenol. I didn't want press to it (shoulder) d have needed a physician's						
	On 5/4/17 at 9:30 a. conducted with LPN administered Norco about the process st	#6, a nurse who on 4/18/17. When asked						
	stated that she would was under a 4 on a s	pain medication, LPN #6 d assess the pain and if it scale from 1-10 she would						
	attempt to redirect th	r apply ice, reposition, or ne resident. When asked if non-pharmacological						
	medications, LPN #6 where non-pharmac	S stated, "Yes." When asked ological interventions dministering pain medications						
	#6 stated, "In the pro	ed in the clinical record, LPN ogress notes." When asked if no Resident #8, LPN #6 stated,						
		if she attempts I interventions prior to in medications to Resident						
	chronic back pain ar	She has a lot if issues like and serious psych (psychiatric) to give her the medication. She						
	six or more." LPN #	thing. Her pain is always a 6 stated that she will 5 Resident #8 if her pain is a 4						
	or less and Norco if	her pain is a 6 or more. .m., further interview was						
	conducted with LPN purpose of the care you know how to car	#14. When asked the plan, LPN #14 stated, "So re for the patient, especially						
	for new nurses." Wh							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	LTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING _				04/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 282	interventions," meant LPN #14 stated, "It m such as a back rub or before giving the med care plan was follower Tylenol on 4/27/17, Licare plan was not follower tylenol on the care plan, ASM member) #2, the DON of the care plan is that a resident can see the rule when asked what the non-pharmacological #8's care plan meant, to try to repositioning before giving pain meant, to try to repositioning	enon-pharmacological on Resident #8's care plan, eans to attempt other things lying the patient down lication." When asked if the d the day she administered PN #14 stated, "That day the owed." m., an interview was (administrative staff I. When asked the purpose of myone working with the needs of that resident." Intervention to "Attempt interventions" on Resident ASM #2 stated, "It means or distraction. It doesn't say dications." When asked if owed on the days nursing rempt non-pharmacological administering pain stated, "If that is what they an would not be followed." It is facility used Lippincott as rd. Pain Management and Pain in part, the following: "It is ty to ensure any resident facility is assessed for pain, or pain in order for the maintain his/her practicable tal and psychosocial nee with the comprehensive	F 2	282				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495413	B. WING			05/04/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA		
F 282	(Director of Nursing) nurse was made awa	ninistrator, ASM #2, the DON and ASM #3, the corporate are of the above concerns.	F	282			
	pain. This information	nih.gov/pubmedhealth/PMH					
F 309 SS=E	aches and pains and information was obtainstitutes of Health. https://www.ncbi.nlm. T0008785/?report=de	RVICES FOR HIGHEST	F	309		5/30/17	
	applies to all care and residents. Each residents. Each residential facility must provide the services to attain or a practicable physical, well-being, consistentials.	mental, and psychosocial					
	applies to all treatment facility residents. Bas assessment of a residents.	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			05/0) 04/2017
	ROVIDER OR SUPPLIER	ILLE		76	REET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY ECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	CEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 309	care plan, and the residual but not limited to the facility must ensure provided to residents consistent with profess the comprehensive pland the residents' goal (I) Dialysis. The facility residents who require services, consistent with profession of practice, the comprehensive plan, and the residents who require services, consistent with the care plan, and the respreferences. This REQUIREMENT by: Based on observation document review and was determined that the care and services to rephysical well-being for survey sample, Resident #8. 1. The facility staff fair non-pharmacological administration of PRN Resident #8.	densive person-centered sidents' choices, including following: d. d. d. d. d. d. d. d. d. d	F3	809	F309 1. Resident #14 s physician was notified of the weight change. Resident #14 s Tylenol order was clarified. RN was in-serviced and counseled for not administering medications to resident # directly after preparation. The physician was notified of the facility s failure to obtain and record ordered blood pressures for resident #7. Staff will be in-serviced on providing non-pharmacological interventions befor administering pain medications to reside #3. Resident #8 discharged from the facility 5/9/17. 2. All residents have the potential to affected by these deficient practices. 3. The DON or designee will in-service licensed nurses on clarification of physician sorders, medication	#5 5 ore ent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING_			C 5/04/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	3/04/2017	
				7600 AUTUMN PARKWAY			
AUTUMN	CARE OF MECHANIC	SVILLE		MECHANICSVILLE, VA 23116			
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F 309	Continued From page	-	F3	09			
	physician order to change based on ob. The facility staff	taff failed to follow the notify the physician of a weight daily weights for Resident #14. failed to follow the physician inistration of Tylenol to		administration, following ph orders, and non-pharmacol- interventions for pain. 4. The DON or designee physician orders daily for for randomly weekly for eight weekly for regorting weight change	ogical will audit our weeks, then veeks. The Unit s with orders s and		
	The findings include: 1. The facility staff failed to attempt/implement non-pharmacological interventions prior to the administration of PRN pain medications to Resident #8. Resident #8 was admitted to the facility on 10/18/16 with diagnoses that included but were not limited to stroke, type two diabetes mellitus, major depressive disorder, anxiety disorder, paralytic gait and muscle spasms. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident #8 was coded as being cognitively impaired in the ability to make daily decisions scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance from one staff member with transfers, ambulation, dressing, hygiene, and bathing; and independent with eating.			recording blood pressure, a documentation of non-phaninterventions for prn pain m daily for four weeks and rar for eight weeks. The Unit M designee will observe four for four weeks, then randon	macological edications idomly weekly lanager or med passes nly weekly for		
				eight weeks to assure that is are given directly after prep will be reviewed by the QAF for three months. 5. Date of compliance: Ju	aration. Audits PI committee		
	Sheet) dated 4/1/1 following prn (as n "Norco Tablet [1] 5 tablet by mouth ev pain.	nt #8's POS (Physician Order 7 through 4/30/17 revealed the eeded) orders: i-325 mg (milligrams) Give 1 ery four hours as needed for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495413	B. WING_			C 05/04/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	I	03/04/2017		
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F 309	pain." Review of Resident (Medication Administ Resident #8 receive following dates and Norco: 4/18/17 at 7: and 1:46 p.m. Tylenol: 4/26/17 at 7: 11:27 a.m. There was no evide non-pharmacologicattempted prior to the Tylenol to Resident 10/18/16 and update following: "Pain d/t (polyneuropathy, and maintain comfort to Interventions: Stanon-pharmacologicate On 5/4/17 at 8:29 a conducted with LPN #14, a nurse who are medication on 4/27/ asked about the proadministering a print of the side of	#8's April 2017 MAR stration Record) revealed that ed Norco and Tylenol on the times: 16 p.m., 4/24/17 at 2:24 a.m., 7:26 p.m., and 4/27/17 at Ince in the clinical record that al interventions were ne administration of Norco and #8. #8's Pain care plan dated ed 3/10/17 documented the (due to) limited mobility, falls, d muscle spasmGoal: Will highest degrees possible.	F3					
	to see if they really then she would ask LPN #14 stated that speak she would loo such as facial expresshe will always atter	the resident the resident and the resident to rate their pain. It for residents who cannot be at non-verbal cues for pain essions. LPN #14 stated that mpt non-pharmacological coadministering pain						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	05/0	04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	would be documented #14 stated, "It should asked if she administ on 4/27/17, LPN #14 MAR and stated, "Yes non-pharmacological documented, LPN #1 think she said her shomight have just given to try to a warm compbecause then I would order." On 5/4/17 at 9:10 a.m conducted with RN (Funit manager. When staff follows prior to a medication, RN #8 stated, "Yes." On 5/4/17 at 9:30 a.m conducted with LPN # administered Norco oprocess prior to admimedication, LPN #6 sthe pain and if it was 1-10 she would admin reposition, or attempt When asked if she almon-pharmacological administering pain men "Yes." When asked with the work of the pain and if it was 1-10 she would admin reposition, or attempt when asked if she almon-pharmacological administering pain men "Yes." When asked with the pain and if it was 1-10 she would administering pain men "Yes."	interventions attempted din the clinical record, LPN be on the MAR." When ered Tylenol to Resident #8 looked at the initials on the s." When asked where interventions were 4 stated, "She requested it. I bulder was hurting. I think I her the Tylenol. I didn't want bress to it (shoulder) have needed a physician's have needed a physician's have needed a physician's asked about the process dministering PRN pain ated, "As a nurse I would try, and a warm compress first edication." When asked if interventions should also be ministering PRN Tylenol, RN h., an interview was 46, a nurse who in 4/18/17. When asked the nistering a prn pain stated that she would assess under a 4 on a scale from hister Tylenol or apply ice, to redirect the resident. ways attempts	F	309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			05/0	;)4/2017
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				7600 AUTUMN PARKWAY			
AUTUMN	CARE OF MECHANICSV	ILLE		MECHANICSVILLE, VA 23116			
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F 309	clinical record, LPN # notes." When asked Resident #8, LPN #6 if she attempts non-pi prior to administering Resident #8, LPN #6 issues like chronic ba (psychiatric) issues as medication. She has	e 91 ald be documented in the 6 stated, "In the progress if she was familiar with stated, "Yes." When asked harmacological interventions prn pain medications to stated, "She has a lot of ck pain and serious psych s well. I just give her the to have the real thing. Her r more." LPN #6 stated that	F3	309			
	pain is a 4 or less and more. The facility policy title Pain Protocol," docun "It is the policy of this resident that is admitt for pain, and/or the pothe resident to obtain practicable level of physychosocial well-bei comprehensive asses Procedure: 1. The intestablish a care plan pain program and the and updated as need evaluate the non-vert resident with dementi systems that could re Non-pharmacological attempted prior to the medications. When it	ed to the facility is assessed of tential for pain in order for or maintain his/her hysical, mental and ng in accordance with the esment and plan of care. Perdisciplinary team will to identify the goals of the care plan will be reviewed ed. 2. The nurse will bal resident and/or the a for non-specific signs and flect pain. 3.					
	a. Documentation of a	administration of cated on the Medication					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		495413	B. WING			l	04/2017
	ROVIDER OR SUPPLIER			70	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116	1 03/	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	of the medication." On 5/4/17 at 1:52 p.m member) #1, the adm (Director of Nursing) nurse was made awa No further information. [1] Norco is a narcotipain. This information National Institutes of https://www.ncbi.nlm T0010590/?report=defended. [2] Tylenol (Acetamin aches and pains and information was obta Institutes of Health. https://www.ncbi.nlm T0008785/?report=defended. 2. The facility staff fanon-pharmacological administration of PRI medication for Resident # 3 was rea 03/11/17 with diagnon to limited to: neuron cancer (1), gastroesed diabetes mellitus (3), hypertension (5), atri. (7), and neuropathy (1) Resident # 3's most in set), a significant characteristic set.	n., ASM (administrative staff hinistrator, ASM #2, the DON and ASM #3, the corporate are of the above concerns. In was presented prior to exit. It pain reliever used to treat in was obtained from The Health. Inih.gov/pubmedhealth/PMH etails Inophen) is used to treat minor also reduces fever. This ined from The National Inih.gov/pubmedhealth/PMH etails. Inih.gov/pubmedhealth/PMH etails. Inih.gov/pubmedhealth/PMH etails. Inih.gov/pubmedhealth/PMH etails. Initerventions prior to the N (as needed) pain ent # 3. Indmitted to the facility on sees that included but were nuscular dysfunction of the ophageal reflux disease (2), anxiety (4), depression, al fibrillation (6), glaucoma	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		5/04/2017		
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F 309	interview for mental signature of the post	as scoring a nine on the brief status (BIMS) of a score of 0 derately impaired of cognition sions. Resident # 3 was ktensive assistance of one wities of daily living. Sorder Sheet) For Resident through 05/03/2017 codone-Acetaminophen G (milligram) Give 1 (one) (of 6 (six) hours as needed for 1/11/2017." "Tylenol (10) 2 (two) tablets by mouth edded for pain. Order Date: codone-Ibuprofen Tablet (9) (one) tablet by mouth every or pain. Order Date: codone-Ibuprofen Tablet (9) (one) tablet by mouth every or pain. Order Date: codone-Ibuprofen Tablet (9) 7.5-325 1 (one) tablet by mouth some ded for pain. Order Tylenol (10) Tablet 325 MG. Tylenol (10) Tablet (9) 7.5-200 MG. Tylenol (10) Tablet (9) 7.5-200 MG. Tylenol (10) Tablet (10) T	F 30	09				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`` '			(X3) DATE COMP	SURVEY LETED
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NAME OF PROVIDER OR SUPPLIER	495413	B. WING	STDI	EET ADDRESS, CITY, STATE, ZIP CODE	05/	04/2017
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2:52 a.m. and 9:28 a. 03/22/17 at 8:58 p.m. a.m. Hydrocodone-Ibuprof administered on 03/1: at 2:41 a.m. and 1:28 a.m., and on 03/31/17 Tylenol 325 MG was 1:46 a.m. and on 03/7 The eMAR (electronic record) for Resident # documented, "Hydrocodone-Acetar MG (milligram) Give every 6 (six) hours as Date: 03/11/2017." "Give 2 (two) tablets b needed for pain. Ord The eMAR dated Apri Hydrocodone-Acetar administered on 04/0 at 4:33 a.m., 04 04/17 9:31 a.m. and 04/05/9:25 a.m., 04/10/17 a a.m. and 9:00 a.m., 0 04/16/17 at 12:47 p.m 19/17 at 3:20 a.m., 04 2:52 p.m., 04/26/17 a a.m., 04/29/17 at 1:08 4:42 a.m. Tylenol 325 MG was 4:01 p.m.	at 10:34 a.m., 03/20/17 at .m., 03/21/17 at 11:17 a.m., ., and on 03/24/17 at 1:03 fen 7.5-200 MG was 2/17 at 1:22 p.m., 03/14/17 p.m., 03/29/17 at 10:19 at 12:30 p.m. administered on 03/12/17 at 16/17 at 11:27 a.m. c medication administration administration administration administration and the second for pain. Order Tylenol (10) Tablet 325 MG. Tylenol (10) Tab	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER	ILLE	- I	7	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 03/	04/2017
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F 309	MG (milligram) Give every 6 (six) hours as Date: 03/11/2017." The eMAR dated Apr Hydrocodone-Acetan administered on 05/0 The care plan for Res documented, "Focus: Neuropathy, Glaucon 03/24/2016. Revision "Interventions" it documented on 05/0 The "Progress Notes 03/11/2017 through 0 and failed to evidence non-pharmacological administration of Hyd Hydrocodone-Acetan On 05/03/17 at 1:20 pconducted with LPN (5). When asked to de administering PRN (a LPN # 5 stated, "I wo what type of pain, des scale one to ten, base administer what is pretthe resident after 30 medication was effect the non-pharmacological attempted, LPN # 5 s non-pharmacological attempted, LPN # 5 s non-pharmacological	minophen Tablet (9) 7.5-325 I (one) tablet by mouth s needed for pain. Order il 2017 revealed, ninophen 7.5-325 MG was 1/17 at 1:49 a.m. sident # 3 dated 07/12/16 Pain related to Arthritis, na. Date Initiated: n on 01/19/2017." Under umented, "Staff to offer interventions as tolerated. 2016." "for Resident # 3 dated 15/01/2017 were reviewed the documentation of interventions prior to the rocodone-Ibuprofen, ninophen and Tylenol. D.m. an interview was (licensed practical nurse) # tescribe the procedure of the sneeded) pain medication, uld ask where the pain is, termine the level of pain on a ted on the level of pain would tescribed, I would reassess minutes to see if the tive. When asked how often tical interventions should be	F	309			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	I	00/04/2011		
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F 309	Continued From page	e 96	F 3	09				
	conducted with RN (manager. When ask of administering PRN stated, "Do a pain as observe nonverbal cuten, ten being most see what was ordere last got pain medicat to the physician's ord 30 to 60 minutes afted determine if it was eff When asked how ofte interventions should "I would try non-phar depending on the resthere is something I of medication to relieve where they would do non-pharmacological	their pain." When asked						
	conducted with RN (rmanager. When ask of administering PRN stated, "Rate the resito ten, ask where the The pain medication according to the pain the use of non-pharm #7 stated, "Non-pharm should be tried every medication and docu what was tried or if the interventions." After	p.m. an interview was registered nurse) # 7, unit ed to describe the procedure I pain medication, RN # 7 dent's pain on a scale of one pain is and to describe it. should be administered level." When asked about nacological interventions, RN rmacological interventions it time before giving PRN pain mented in the nurse's notes are resident refused the reviewing the MARs dated of 2017 and the progress						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING	R WING		C 05/04/2017	
	ROVIDER OR SUPPLIER	L		s 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY 1ECHANICSVILLE, VA 23116	<u> </u> 05/0	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Resident # 3, RN # 1 documentation of non interventions attempted of PRN pain medication wasn't done." On 05/04/17 at approdict (administrative staff madministrator, and AS were made aware of the No further information References: 1. The uncontrolled good the body. Cancerous malignant cells. This from the website: https://medlineplus.go. 2. Stomach contents the esophagus and in was obtained from the https://www.nlm.nih.go. 3. A chronic disease is regulate the amount of information was obtain https://www.nlm.nih.go. 4. Fear. This information website: https://www.nlm.nih.go. 4. Fear. This information website: https://www.nlm.nih.go. #summary.	17 through 05/01/2017 for was asked if there was a-pharmacological ed prior to the administration on. RN # 1 stated, "No, it ximately 1:50 p.m. ASM nember) # 1 the SM # 2, director of nursing, the findings. In was provided prior to exit. I was provided prior to exit.	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING	B. WING		C 05/04/2017	
	ROVIDER OR SUPPLIER			s 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 05/0	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	essure.html. 6. A problem with the heartbeat. This information website: https://www.nlm.nih.gon.html. 7. A group of disease optic nerve. This information the website: https://www.nlm.nih.goml. 8. Nerve damage. The from the website: https://www.google.com/lines/	speed or rhythm of the mation was obtained from sov/medlineplus/atrialfibrillati s that can damage the eye's armation was obtained from sov/medlineplus/glaucoma.ht sov/medlineplus/glaucoma.ht si information was obtained som/#q=neuropathy+nih. ailable in combination with different combination ed for different uses. Some ation products are used to evere pain. Other ation products are used to codone is in a class of biate (narcotic) analgesics ications called antitussives. It is pain by changing the way is system respond to pain. Obtained from the website: by/druginfo/meds/a601006.h	F	309			
	menstrual periods, co toothaches, backache	olds and sore throats,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 05/04/2017		
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	E	03/04/2017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 309	vaccinations (shots), Acetaminophen may pain of osteoarthritis breakdown of the linit Acetaminophen is in analgesics (pain relie reducers). It works by senses pain and by of information was obtain	and to reduce fever. also be used to relieve the (arthritis caused by the	F3	309				
	Resident #7 was adm with diagnoses that in to: diabetes, high blochronic pain, gastroe anemia (too low bloof of the sacral region (i	nitted to the facility on 1/7/15 included but were not limited od pressure, depression, sophageal reflux disease, d count (1)), pressure ulcer inflammation or sore over a ulting from prolonged						
	assessment reference resident as scoring a interview for mental such she was severely implicately decisions. Residence requiring extensive as	S (minimum data set) erly assessment, with an e date of 2/3/17, coded the zero on the BIMS (brief status) score, indicating that paired to make cognitive dent #7 was coded as essistance of one or more of her activities of daily						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495413	B. WING		05/04/2017		
	ROVIDER OR SUPPLIER CARE OF MECHANICS	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/04/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION		
F 309	Continued From page	-	F 30	9			
	"Weekly B/P (blood	dated, 4/28/16, documented, pressure) check one time a rsday) for HTN (hypertension re)."					
	April 2017 documer time a day every Th documented a chec on 4/5/17, 4/12/17,	on administration record) for inted, "Weekly B/P check one itu for HTN." The MAR ik mark and the nurse's initials 4/20/17 and 4/27/17. There ion of the blood pressures on					
	11:17 a.m. The nurs 12:40 p.m. did not o	se's notes for 4/5/17 d pressure taken on 4/4/17 at se's note dated, 4/12/17 at document a blood pressure. e's notes dated 4/20/17 or					
	medical record, doc on 4/5/17 or 4/12/17 pressure "0/0 mmH was documented. T	al signs" tab in the electronic numented no blood pressure 7. On 4/20/17 the blood g (millimeters of mercury)" here was a blood pressure 7/17 at 9:15 a.m. of 133/69					
	revised on 2/27/17, Altered cardiac prof HTN, PVD (periphe abnormal condition outside the heart) (3 (common disorder of plaques consisting lipids form on the in to decreased blood	e care plan dated, 4/11/16 and documented in part, "Focus: fusion relate to diagnosis of ral vascular disease) (any affecting blood vessels and Atherosclerosis of aorta of the arteries in which mostly of cholesterol and ner arterial/aortic wall leading flow (4))." The "Interventions", "Assess vital signs."					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495413	B. WING		C 05/04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 309	Continued From page	e 101	F 30	09	
	practical nurse) #5, o asked what staff show written an order for a every Thursday, LPN should check the blood Thursday." When ask readings were documing the electronic record the vital signs tab in the vital signs tab was consumit manager, on 5/3/what staff should do in an order for a blood proposed the signs tab was reviews tated, "It's not therestated, "ASM #3, corporate in administrator, ASM #ASM #3, corporate in nurse) #2, the transiting made aware of the at 5:35 p.m. No further information (1) Barron's Dictionar Non-Medical Reader, Chapman, page 33. (2) Barron's Dictionar	ted where blood pressure tented, LPN #5 stated, "It's and in a progress note or in the computer." ducted with LPN #10, the 17 at 3:18 p.m. When asked if the physician has written bressure to be taken every tated, the blood pressure R. Technically, it should not ted on unless the blood erted." The MAR and vital ed with LPN #10. LPN #10. The order was not put into the interest of			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495413	B. WING		C 05/04/2017		
	ROVIDER OR SUPPLIER	/ILLE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 33.6 1.2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
F 309	Non-Medical Reader Chapman, page 447 (4) Barron's Dictiona	ary of Medical Terms for the , 5th edition, Rothenberg and	F 309				
	change based on da Resident #14 was ac 10/24/16 with a read diagnoses included to congestive heart failurespiratory failure, fra blood pressure, sleet breathing while some chronic obstructive pand atrial fibrillation (contractions of the ac	diffy the physician of a weight ally weights for Resident #14. Imitted to the facility on mission on 11/21/16. Her but were not limited to: are (CHF), acute and chronic facture of the lower leg, high or apnea (periods of not geone sleeps (1)), anemia, almonary disease (COPD),					
	assessment, a quarter assessment reference resident as scoring a interview for mental swas cognitively intact. The resident was cognitively intact. The resident was coded as or set up assistance was assistance was coded as or set up assistance was as a supplication of the physician order.	S (minimum data set) erly assessment, with an ee date of 3/14/17, coded the 14 on the BIMS (brief status) score, indicating she t to make daily decisions. ded as requiring extensive of her activities of daily living. nly requiring supervision after is provided for eating. dated, 11/21/16, n weight daily; one time a day					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 05/04/2017		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		03/04/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 309	MD (medical doctor) The MAR (medication February 2017 doctor) one time a day for magin of 2 lbs. in one notify MD." The foll documented: 2/5/17 - 249.8; 2/6/2/18/17 - 252.2; 2/1 pounds. The March 2017, Moveight daily; one tin there is a weight gain one week, notify gains were docume 3/8/17 - 256; 3/9/17 3/16/17 - 257.8; 3/1 pounds. 3/17/17 - 250.2; 3/27/1/2/1/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	or 5 lbs. in one week, notify)." on administration record) for umented, "Obtain weight daily; nonitoring. If there is a weight day or 5 lbs. in one week, owing weight gains were 17 - 251.9, a gain of 2 pounds. 19/17 - 254.2, a gain of 2 AR documented, "Obtain ne a day for monitoring. If in of 2 lbs. in one day or 5 lbs. MD." The following weight	F3	09				
		s's notes from 2/1/17 through ence any documentation of						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICS	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	
F 309	gains. The comprehensive and revised on 3/21/ "Focus: Risk for fluid characterized by fluid mucous membranes integrity related to: di "Interventions" docur RD (registered dietic facility routines." An interview was corpractical nurse) #4 or above daily weight on When asked what is the above order, LPN weigh the person evaccording to the order is documented, LPN in the progress notes When asked if the 24 clinical record, LPN # both but definitely the An interview was corunit manager, on 5/3 to review the above of what staff should do, to weigh the resident the weight is more the five pounds in a ween notification is documented and the doctor was notified. The facility policy, "Compared to the staff should, the staff should be in a nurse the doctor was notified.	care plan dated, 10/25/16 17, documented in part, output exceeding intake divolume deficit; dry skin and poor skin turgor and furetics, CHF." The mented in part, "Notify MD & fian) of weight change per inducted with LPN (licensed in 5/3/17 at 3:10 p.m. The reder was reviewed with her. expected of the nurse with N #4 stated, "We have to fivery day and call the doctor fier." When asked where that #4 stated, "It's documented and or 24 hour book." If hour book was part of the progress note." Inducted with LPN #10, the progress note." Inducted with LPN #10, the progress note in a day or k." When asked where this ented, LPN #10 stated, "It progress note to say at least	F3	309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED	
			7 55.125.			С	
		495413	B. WING			05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	of a change in resided Physician/Family/Res notified as soon as the change in condition a In "Fundamentals of I Patricia A. Potter and Inc; Page 419. "The directing medical trea obligated to follow phelieve the orders are clients." Administrative staff madministrator, ASM #ASM #3, corporate numrse) #3, the transitimade aware of the abs:35 p.m. No further information (1) Barron's Dictionar Non-Medical Reader, Chapman, page 45. (2) Barron's Dictional Non-Medical Reader, Chapman, page 55. b. The facility staff fai orders for the administrative staff fai orders	priately intervene in the event and condition. The sponsible Party will be enurse had identified the and the resident is stable." Nursing" 6th edition, 2005; Anne Griffin Perry; Mosby, physician is responsible for atment. Nurses are ysician's orders unless they en in error or would harm sember (ASM) #1, the 2, the director of nursing, arse, and RN (registered onal care coordinator, were pove findings on 5/3/17 at an was provided prior to exit. The yof Medical Terms for the 5th edition, Rothenberg and and ry of Medical Terms for the 5th edition, Rothenberg and led to follow the physician	F	309			
		irs as needed for Fever."					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<u> </u>	(X3) DATE SURVEY COMPLETED C 05/04/2017		
495413		B. WING				
ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	05/04/2017		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	O BE COMPLETION		
Continued From pag	e 106	F 30	9			
administration record Tablet 325 MG; Give hours as needed for documented the reside 2/21/17 at 9:04 a.m. documented. Review reveal documentation Review of the vital size record did not reveal had a fever. The April 2017 MAR 325 MG; Give 2 table needed for Fever." Tresident received Tyl p.m. for a pain level onotes did not reveal Resident #14. Reviewed.	2) documented, "Tylenol 2 tablet by mouth every 6 Fever." The MAR dent received Tylenol on and a pain level of "6" was of the nurse's notes did not n of a fever for Resident #14. gns section of the clinical any evidence the resident documented, "Tylenol Tablet et by mouth every 6 hours as he MAR documented the enol on 4/28/17 at 12:10 of "6." Review of the nurse's documentation of a fever for ew of the vital signs section of					
325 MG; Give 2 table needed for Fever." T resident received Tyl for a documented pa nurse's notes did not fever for Resident #1 section of the clinical evidence the residen The comprehensive of did not address fever. An interview was corrected.	et by mouth every 6 hours as he MAR documented the enol on 5/1/17 at 12:55 p.m. in level of "4." Review of the reveal documentation of a 4. Review of the vital signs record did not reveal any t had a fever. care plan dated, 10/24/16, rs.					
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR The February 2017 Madministration record Tablet 325 MG; Give hours as needed for documented the residence of the vital size of the vital s	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 The February 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 2/21/17 at 9:04 a.m. and a pain level of "6" was documented. Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever. The April 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 4/28/17 at 12:10 p.m. for a pain level of "6." Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 F 30 The February 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 2/21/17 at 9:04 a.m. and a pain level of "6" was documented. Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever. The April 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 4/28/17 at 12:10 p.m. for a pain level of "6." Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever. The May 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident had a fever. The May 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented in fever for Resident #14. Review of the vital signs section of the clinical record did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever. The comprehensive care plan dated, 10/24/16, did not address fevers. An interview was conducted with LPN (licensed practical nurse) #4, on 5/3/17 at 3:10 p.m. The	SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 106 The February 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 2/21/17 at 9:04 a.m. and a pain level of "6" was documented. Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident received Tylenol on 4/28/17 at 12:10 p.m. for a pain level of "6," Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident received Tylenol on 5/11/7 at 12:55 p.m. for a documented pain level of "4." Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the nurse's notes did not reveal any evidence the resident had a fever. The comprehensive care plan dated, 10/24/16, did not address fevers. An interview was conducted with LPN (licensed practical nurse) #4, on 5/3/17 at 3:10 p.m. The		

	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495413	B. WING			C 05/04/2017	
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 03/	04/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Tylenol for pain, base #4 stated, "No, they we new order." An interview was concunit manager, on 5/3/ for Tylenol above was When asked if the number for pain, based on the stated, "According to given for fever." When should do, LPN #10 sthe order and or get a pain for the resident." The facility policy, "Phauthorization and Concepharmacy" document not administer medical upon the order of a Plauthorized to prescribillnesses." Administrative staff madministrator, ASM #3, corporate number 1835 p.m.	dif the nurse could give the d on the above order, LPN yould have to get a whole ducted with LPN #10, the 17 at 3:17 p.m. The order reviewed with LPN #10. The could give the Tylenol above order, LPN #10 this order, it should only be a sked what the staff tated, "They need to clarify new order for Tylenol for munication of Orders to ed in part, "1. Facility should ations or biologicals except thysician/Prescriber lawfully be for and treat human ember (ASM) #1, the 2, the director of nursing, urse, and RN (registered onal care coordinator, were love findings on 5/3/17 at	FS	309			
F 311 SS=D	TREATMENT/SERVIO		F:	311			5/26/17
	(a)(1) A resident is given treatment and service	ven the appropriate s to maintain or improve his					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTIO A. BUILDING			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 05/04/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 311	Continued From page or her ability to carry living, including those of this section. This REQUIREMENT by: Based on resident in facility document revireview, it was determ failed to provide restor of care for one of 27 is sample, Resident #14 The facility staff failed ambulation services to of care. The findings include: Resident #14 was ad 10/24/16 with a readr diagnoses included be congestive heart failurespiratory failure, fra blood pressure, sleep breathing while some chronic obstructive puand atrial fibrillation (is contractions of the atrial	e 108 out the activities of daily e specified in paragraph (b) is not met as evidenced terview, resident interview, ew and clinical record ined that the facility staff orative services per the plan residents in the survey 4. If to provide restorative to Resident #14 per the plan mission on 11/21/16. Her tut were not limited to: tre (CHF), acute and chronic cture of the lower leg, high to apnea (periods of not one sleeps (1)), anemia, ulmonary disease (COPD),		311		ot / r of rice	
	assessment reference resident as scoring a interview for mental s was cognitively intact The resident was cod	s (minimum data set) erly assessment, with an e date of 3/14/17, coded the 14 on the BIMS (brief tatus) score, indicating she to make daily decisions. led as requiring extensive f her activities of daily living.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			C 05/04/2017	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	l	00/04/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 311	An interview was cor 5/3/17 at 3:44 p.m. Ftoday (5/3/17) was the had been walked with Resident #14 stated, day, which what the regets pulled off restora a CNA (certified nurse) #2, the MDS of When asked who over nurse) #2, the MDS of When asked who over nursing program, RN asked if a physician of restorative nursing, Faware of." RN #2 was documentation that even in a restorative program on 5/3/17 at 5:14 p.m. "Restorative Ambulate of April 2017 for Rese "Problem/Need" documentations" documentations" documentations" documentations" documentations" documentations" documentations" documentations ambulate 50. The "Restorative Am April 2017 document restorative ambulation days: The week of April 2 - received restorative in the storative in the second of the second o	equiring only supervision after is provided for eating. Iducted with Resident #14 on Resident #14 stated that the first day in weeks that she in the restorative aide. "They can't walk me every restorative aide told me. She eative to work on the floor as ing assistant)." Iducted with RN (registered for the restorative was required for the restorative was required for the restorative was required for the resident #14 was am. In RN #2 presented the diston Program Daily Record widenced Resident #14 was am. In RN #2 presented the diston Program Daily Record was required for the resident #14. The sumented, "Resident is able to colling walker) and min assist to 50 feet." The mented in part, "15 min week, device needed feet. In the program of the following was a specific program on the following was program on the following was program on the following was provident was required for the resident received on program on the following was provident was provid	F3	11			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495413	B. WING		C 05/04/2017		
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	05/04/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETION		
F 311	The week of April 1 not receive any res The week of April 2 received restorative The comprehensive documented in part for ambulation relat device, unsteady be documented in part plan. Resident will 6/7 days a week." An interview was coat 5:14 p.m. When receiving the restor plan of care, RN #2 when the restorativ When asked if som #2 stated, "Yes." W	e nursing on four days. 6 - 22, 2017, the resident did torative nursing. 3 - 29, 2017, the resident e nursing on six days. e care plan dated, 4/4/17, c., "Focus: Requires assistance red to: Requires assistive alance." The "Interventions" c., "Ambulation per restorative practice 15 minutes a day for conducted with RN #2 on 5/3/17 asked why the resident is not ative nursing program per her e stated, "We've had times e aid is pulled to the floor." reone else should cover, RN then asked if a resident has a tive care, should it be	F 31	1			
	Nursing Program" of The purpose of the is to allow our facilic choice by delivering meets the needs of will focus on achieve physical, mental and our residents. The improve or maintain residents. The goal improve or maintain to ensure that the redecline that is mediated.	Introduction to the Restorative documented in part, "Purpose: restorative nursing programs ties to be the providers of g quality restorative care that each resident. Our facilities ring and maintaining optimal d psychosocial functioning for goal for each resident is to a current functioning for our or current functional level, and esident does not exhibit any ically avoidable. Procedure: sing programs are carried out					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		495413	B. WING		C 05/04/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 03/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO	
F 311	and are provided by I restorative aides. The measurable goals, ar quarterly (or more oft programs are provide or less. Nursing man supervision of the rest therefore responsible implementation, prog documentation, reviewith therapists, and pursing staff will be trest through staff develop Goals: Supportive an used to increase our independence. In the is to maintain the resindependence and prowhere prevention is a degenerative disease disability is progressivintervention." Administrative staff madministrator, ASM #ASM #3, corporate nurse) #3, the transitimade aware of the at 5:35 p.m. No further information (1) Barron's Dictionar Non-Medical Reader, Chapman, page 45. (2) Barron's Dictionar Dictionar Non-Medical Reader, Chapman, page 45. (2) Barron's Dictionar	the nursing department, icensed nurses and trained ese programs employ and each resident is evaluated en, if need be). Restorative and in groups of four residents agement will provide storative programs and is for program	F3	11		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495413	B. WING			05/	04/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	'ILLE	•	7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 314 SS=D	(i) A resident received professional standard pressure ulcers and dulcers unless the indidemonstrates that the (ii) A resident with professional standard healing, prevent infection developing. This REQUIREMENT by: Based on observation document review and was determined that provide would care in healing and prevent if for one of 27 resident Resident #7. LPN (licensed practic observed cleaning healing	Based on the sement of a resident, the nat- s care, consistent with ds of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent with ds of practice, to promote ction and prevent new ulcers is not met as evidenced on, staff interview, facility d clinical record review, it the facility staff failed to a manner to promote infection of a pressure sore, its in the survey sample, cal nurse) #10 was not er scissors prior to cutting a need into Resident #7's	F	314	F314 1. LPN #10 was educated and counseled by the DON on providing wound care in a manner to promote healing and prevent infection. Resident 7 sustained no ill effects due to this deficient practice. 2. All residents receiving wound care have the potential to be affected by this deficient practice. 3. The DON or designee will in-servic licensed nurses on providing wound cain a manner which promotes healing an	s S ce ire	5/30/17	
	The findings include:				prevents infection. 4. The Unit Managers or designees vobserve wound care on 25% of resider	vill nts		
	⊢Resident #7 was adn	nitted to the facility on 1/7/15	1		with wounds weekly for four weeks, the	'n	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413 B. WING				C 5/04/2017	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		3/04/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	to: diabetes, high blo chronic pain, gastroe anemia (too low bloo of the sacral region (i bony prominence respressure to the area dementia. The most recent MDS assessment, a quarte assessment reference resident as scoring a interview for mental she was severely imputed ally decisions. Resident as scoring a compared by the same severely imputed in the second of th	ncluded but were not limited od pressure, depression, sophageal reflux disease, d count (1)), pressure ulcer inflammation or sore over a sulting from prolonged (2)), dysphagia, and S (minimum data set) erly assessment, with an er date of 2/3/17, coded the zero on the BIMS (brief status) score, indicating that paired to make cognitive dent #7 was coded as ssistance of one or more of her activities of daily Skin Conditions, the resident an unstageable pressure is a pressure injury.**	F 3 ²		esults of le QAPI		
	damage to the skin a usually over a bony p medical or other devi as intact skin or an o	nd underlying soft tissue prominence or related to a ce. The injury can present pen ulcer and may be curs as a result of intense					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495413		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495413	B. WING				
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	05/04/2017		
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F 314	and/or prolonged prombination with shitssue for pressure affected by microcling co-morbidities and of the physician order "Sacrum one time a sacrum with wound hydrofera blue* soa cover with dry dress "Hydrofera Blue Agentian violet and mantibacterial agents Wound Care, Libert be effective against microorganisms four methicillin-resistant (MRSA), vancomycand Candida. (5) On 5/3/17 at 10:50 nurse) #10 was obscare to Resident #7 gathered her supplipositioned at the do She pulled scissors treatment cart, and approximately 1/2 in hydrofera blue. She medication cup. She water in the cup with clean her scissors pure to the pulled dresser in the cup with clean her scissors pure moved the old dresserum; she then research and combined and resident #7's over the removed the old dresserum; she then research and combined and the pulled scissors pure moved the old dresserum; she then research and combined and the pulled scissors pure moved the old dresserum; she then research and combined and the pulled scissors pure moved the old dresserum; she then research and combined and the pulled scissors pure moved the old dresserum; she then research and combined and the pulled scissors pure moved the old dresserum; she then research and combined and the pulled scissors pure moved the old dresserum; she then research and combined and combin	ressure or pressure in the tolerance of soft and shear may also be mate, nutrition, perfusion, condition of the soft tissue. (4) res dated, 3/1/17, documented, and day for wound care; cleanse cleanser pat dry and apply ked with sterile water and sing daily." A foam dressing bound with methylene blue (GV/MB) (Hydrofera Blue; Hollister yville, IL) has been shown to	F 31	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495413 B. W				C 05/04/2017	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		00.04.2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	Continued From page	e 115	F 3	14			
	took the small piece	ound cleanser. She then of hydrofera blue and placed und cavity, and then she ing.					
	5/3/17 at 1:54 p.m. Labove observation of and was asked when LPN #10 stated, "The the bleach wipes after scissors should be cladressing, LPN #10 strusing that cart (treatment when I put then should clean the scissors the scissors with the scissors should state of the scissors with the scies with the scissors with the	d inside a resident's wound,					
	involves strategies us the overall number of prevent or reduce the microorganisms from from one place to and involves meticulous h clean environment by using clean gloves, s prevention of direct c and supplies. No 'ste This technique may a An interview was con director of nursing; of	ed in part, "Clean technique sed in patient care to reduce if microorganisms or to exist of transmission of one person to another or other. Clean technique nand-washing, maintaining a preparing a clean field, terile instruments and ontamination of materials rile to sterile' rules apply. Also be termed 'non-sterile." Inducted with ASM #2, the in 5/3/17 at 5:58 p.m. ASM as access to the treatment					
	Administrative staff m	nember (ASM) #1, the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495413	B. WING			05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
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	administrator, ASM #ASM #3, the corporat transitional care coord the above findings on No further information (1) Barron's Dictionar Non-Medical Reader, Chapman, page 33. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 155. (3) This information w following website: http://www.npuap.org clinical-resources/npu. (4) This information w following website: http://www.npuap.org clinical-resources/npu. (5) This information w following website: https://www.ncbi.nlm. 17508/ FREE OF ACCIDENT HAZARDS/SUPERVI CFR(s): 483.25(d)(1)(d) Accidents. The facility must ensu. (1) The resident envir from accident hazards.	2, the director of nursing, e nurse and RN #3, the dinator, were made aware of 5/3/17 at 5:35 p.m. In was provided prior to exit. If y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and was obtained from the Iresources/educational-and-irap-pressure-injury-stages/ was obtained from the Iresources/educational-and-irap-pressure-injury-stages/ was obtained from the Inih.gov/pmc/articles/PMC47 SION/DEVICES (2)(n)(1)-(3) Ire that -		314			5/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495413	B. WING _		05/04/2017		
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	'		
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F 323	appropriate alternative bed rail. If a bed or somust ensure correct is maintenance of bed or to the following element (1) Assess the reside from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beappropriate for the resident or reside informed consent prior (3) Ensure that the beappropriate for the resident or reside informed consent prior (3) Ensure that the beappropriate for the resident or the resident of the re	facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited ents. Int for risk of entrapment installation. In dend benefits of bed rails with intrepresentative and obtain or to installation. In ded's dimensions are sident's size and weight. It is not met as evidenced In, staff interview and facility as determined that the store chemicals in a safe of soiled utility rooms, (soiled as Summer unit) and one of significant closet across the hall in department). In department is served in the unlocked side the summer unit:	F3	F323 1. The chemicals were immedi removed from the indicated soile room and housekeeping closet. housekeeping closet was locked immediately. 2. All residents who can acces housekeeping closets and/or soil rooms have the potential to be at this deficient practice. 3. The housekeeping and mair staff and clinical staff were educa proper storage of chemicals by administrator or designee. 4. The Maintenance Director/d will audit housekeeping closets to that they are locked 5 times a we weeks. The Unit Managers/designaudit soiled utility rooms for the part of the pa	s led utility The s led utility ffected by ntenance ated on esignee o assure eek for 8 gnee will		
	cleaner	iner of Ecolution glass		of chemicals five times weekly for weeks. Results of audits will be	or 8		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495413	B. WING		C 05/04/2017		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	03/04/2017		
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F 323	Continued From page 118 cleaner -One three liter container of disinfectant bowl cleaner -One three liter container of Ecolution odor remover - One two liter container of BioRenewables glass cleaner		F 323	QAPI committee monthly for 3 mor review and revisions as needed 5. Date of compliance: June 16,			
	The findings include: On 5/2/17 at 2:16 p.m., observation of the soiled utility room beside the summer unit was conducted. The door to the room was unlocked and the following chemicals were observed in the room: -One 32 ounce container of TB-Cide Quat disinfectant solution -One 67.6 ounce container of BioRenewables glass cleaner						
	closet across the hal was conducted. The unlocked and the fol observed in the roon - One three liter contacleaner -One three liter -One three -One three liter -One three liter -One three liter -One three li	m. observation of the janitor Il from the rehab department e door to the room was lowing chemicals were n: tainer of neutral disinfectant ainer of Ecolution glass ainer of disinfectant bowl ainer of Ecolution odor iner of BioRenewables glass					
	were observed prope	servations, two residents elling themselves in all adjacent to the soiled utility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495413	B. WING			05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		7	STREET ADDRESS, CITY, STATE, ZIP CODE		
				ı,	MECHANICSVILLE, VA 23116		
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F 323	Continued From page room and the janitor of observed in the rooms rooms. On 5/2/17 at 2:25 p.m conducted with OSM director of environments tated all chemicals with locked rooms. OSI chemicals in the unloce OSM #3 stated, "That discarded the chemicals in the unloce OSM #3 stated the jan locked. At this time, Oprovide a policy regar chemicals. On 5/2/17 stated she couldn't find the couldn	closet. No residents were is or attempting to enter the so or atte		323	DEFICIENCY)	NIE.	
	cleaner documented, Causes serious eye ir The safety data sheet cleaner documented, Causes severe skin b Harmful if inhaled. Ha The safety data sheet	ritation" i for the neutral disinfectant "Hazard Statements: urns and eye damage. armful if swallowed" i for the Ecolution glass					
	cleaner documented, Causes mild skin irrita	"Hazard statements: ation. Causes eye irritation.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		E SURVEY PLETED
		495413	B. WING			C / 04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
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F 328 SS=D	Harmful if inhaled. Harmful if inhaled. Harmful if inhaled. Harmful if inhaled. Harmful safety data sheet remover documented Causes mild skin irritation" No further information TREATMENT/CARE CFR(s): 483.25(b)(2)(c)(d)(e)(e)(e)(e)(e)(f)(e)(e)(f)(e)(f)(f)(f)(f)(f)(f)(f)(f)(f)(f)(f)(f)(f)	allowed" It for disinfectant bowl "Hazard statements: For the Ecolution odor Indicate the Indicate the Indicate odor Indicate the Indicate the Indicate odor Indicate the Indicate the Indicate of Indicate odor Ind		328		5/26/17
	receives the appropris	ate treatment and services				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _		١,	C 05/04/2017
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1	300-4/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 328	including but not limitidiarrhea, vomiting, dabnormalities, and not limitidiarrhea, vomiting, dabnormalities, and not limitidiarrhea, vomiting, dabnormalities, and not limitidiarrhea consists standards of practice physician orders, the person-centered car goals and preference (i) Respiratory care, and tracheal suction that a resident who rincluding tracheosto suctioning, is provide professional standar comprehensive person-sidents' goals and this subpart. (j) Prostheses. The resident who has a pand assistance, constandards of practice person-centered car and preferences, to prosthetic device. This REQUIREMEN by: Based on observation interview, and clinicated determined that the proper treatment and for two of 27 resident Resident #14 and #1	cations of enteral feeding ted to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers. Parenteral fluids must be tent with professional e and in accordance with e comprehensive e plan, and the resident's es. including tracheostomy care ing. The facility must ensure needs respiratory care, my care and tracheal ed such care, consistent with ds of practice, the on-centered care plan, the preferences, and 483.65 of facility must ensure that a prosthesis is provided care sistent with professional e, the comprehensive e plan, the residents' goals wear and be able to use the T is not met as evidenced on, resident interview, staff al record review, it was facility staff failed to provide d services for respiratory care ts in the survey sample,	F 3	F328 1. The CPAP mask was clear bagged, and the oxygen nasal tubing for resident #14 was chabagged. The oxygen tubing res was changed and bagged. 2. All residents receiving oxygen the potential to be affected by the pote	cannula anged and ident #13 gen have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING _				C / 04/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	104/2017
					600 AUTUMN PARKWAY		
AUTUMN	CARE OF MECHANICSV	ILLE			MECHANICSVILLE, VA 23116		
24.0.1=	CLIMMA DV CT	ATEMENT OF DEFICIENCIES			· T		0(5)
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F 328	Continued From page	e 122	F3	328			
	mask, CPAP mask ar	nd oxygen nasal cannula in a			deficient practice.		
	sanitary manner for R	Resident #14.			3. The DON or designee will educate		
					clinical staff on the proper maintenance	e of	
		iled to ensure Resident			CPAP masks and oxygen tubing.		
		annula and tubing was			4. The Unit Managers or designees		
	properly bagged in a	sanitary manner.			audit 25% of residents receiving oxyge therapy and CPAP usage weekly for for		
	The findings include:				weeks and then randomly for eight we		
	The infairige include.				Results of audits will be taken to the Q		
	1. Resident #14 was	admitted to the facility on			committee monthly for 3 months for		
	10/24/16 with a readn	nission on 11/21/16. Her			review and revisions as needed.		
	diagnoses included b	ut were not limited to:			5. Date of compliance: June 16, 201	7.	
		re (CHF), acute and chronic					
		cture of the lower leg, high					
		apnea (periods of not					
		one sleeps (1)), anemia,					
	and atrial fibrillation (r	ulmonary disease (COPD),					
		ria of the heart causing					
		ventricles decreasing the					
	heart output (2)).	Ŭ					
	The most recent MDS						
		erly assessment, with an					
		e date of 3/14/17, coded the					
		14 on the BIMS (brief					
		tatus) score, indicating she to make daily decisions.					
		led as requiring extensive					
		of her activities of daily living.					
		ring only supervision after					
		s provided for eating. In					
	Section O - Special T	reatments, Procedures, and					
		nt was coded as having					
	received oxygen while	e a resident at the facility.					
	Resident #14's room	was observed during the					
		ty on 5/2/17 at 12:40 p.m.					
	The nebulizer mask w	vas sitting on the bedside					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED	
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	ROVIDER OR SUPPLIER	SVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		1 00/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 328	exposed to air. The machine, was on the The nasal cannular through the nose) woxygen tubing was. Resident #14's room 5:07 p.m. All respiration a plastic bag. The 5/1/17. Resident #14's room 8:20 a.m. The reside mask for a treatmer placed in the reside was resting on the B. The oxygen tubing was respirated with see there were any conducted with Resting was respirated with Resting was b." When asked this, Resident #14 s. The physician order "11/21/16 - Oxygen minute) via nasal carespiratory needs.	a protective bag or covering, e oxygen concentrator, e opposite side of the bed. (tubing to administer oxygen vas lying on the floor. The dated 5/1/17. In was observed on 5/2/17 at atory equipment was covered e oxygen tubing was dated In was observed on 5/3/17 at ent was using the nebulizer of the oxygen tubing was int's nose. The CPAP* mask pedside table, not in a bag.	F 32	8		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	· ,	DATE SURVEY COMPLETED
		495413	B. WING _		_	C 05/04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STA 7600 AUTUMN PARKWAY MECHANICSVILLE, VA		03/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	and PRN (as needed 11/22/16 - CPAP Q Hevening shift for Resj 5/1/17 - Change nebic (every) week, in their for change for 2 weel. The comprehensive and revised on 3/7/13 "Altered Cardiac/Res CPAP at hs (bedtime The "Interventions" dinebulizer tubing and therapy as ordered." 11/1/16, documented oxygen R/T (related the process." The "Interventions" dinebulizer tubing and therapy as ordered." 11/1/16, documented oxygen R/T (related the process." The "Interventions" dinebulizer oxygen at treatments as orders cannula q week." On 5/3/17 at 3:54 p.m. conducted with RN (manager. When asked with tubing if it is found on "You need to go get madministrative staff madministrative staff madministrative staff madministrative staff madministrator, ASM #ASM #3, the corporational care coor the above findings or On 5/4/17 at approximal care coor the above findings or On 5/4/1	IS (every bedtime) every biratory needs. Ulizer tubing and bag q morning every Mon (Monday) ks. Care plan dated, 10/25/16 7, documented in part, p (respiratory) Functioning;), CHF, Pacemaker, COPD." ocumented in part, "Change bag q week. O2 (oxygen) The care plan dated, in part, "Resident requires o) CHF, COPD, disease entions" documented in part, is ordered. Aerosol/nebulizer or change oxygen tubing, a., an interview was registered nurse) #7, the unit red how respiratory mask, oxygen tubing and be stored, RN #7 stated, "It is a plastic bag when not in mat happens to oxygen the floor, RN #7 stated, new tubing." Thember (ASM) #1, the 2, the director of nursing, the nurse and RN #3, the dinator, were made aware of	F	328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING	B. WING		C 05/04/2017	
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116	1 05/1	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328	did not have a policy equipment. The facility equipment when not in In "Fundamentals of In Patricia A. Potter and Inc; Page 648. "Box of Health Care-Assoc Respiratory Tract Otherapy equipment." No further information (1) Barron's Dictionar Non-Medical Reader, Chapman, page 45. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 55. (3) This information we following website: www.webmd.com/sle 2. The facility staff far #13's oxygen nasal caproperly bagged in a Resident #13 was add 3/16/17 with the diagroparanoid schizophren chronic obstructive partery disease, and himost recent MDS (Miadmission/5-day asset)	m. ASM #2 stated the facility on storing respiratory by practice is to bag in use. Nursing" 7th edition, 2009: Anne Griffin Perry: Mosby, 34-2 Sites for and Causes siated Infections under contaminated respiratory In was provided prior to exit. If y of Medical Terms for the 5th edition, Rothenberg and Rot	F	328			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G		PLETED
		495413	B. WING		ı	C 04/2017
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 328	in ability to make daily out of a possible 15 of for Mental Status) extensive assistance hygiene; limited assis supervision for eating incontinent of bowel at On 5/2/17 at 12:40 p. room for Resident #1 oxygen tubing from the over the over-bed tab dangling in the air, and On 5/2/17 at 5:17 p.m made. There was no observation. On 5/4/17 at 7:50 a.m of Resident #13. He wheelchair was next tubing from the tank to was coiled up in the swrapped around his sof the wheelchair. The bagged. On 5/4/17 at 7:55 a.m #4 (Licensed Practical nurse for the day, she bagged and not wrapped on 5/4/17 at 1:52 p.m (Administrative Staff Director of Nursing (Administrative St	s being moderately impaired y life decisions, scoring a 9 on the BIMS (Brief Interview am. The resident required for transfers, dressing, and stance for bathing; y; and was coded as and bladder. m., an observation of the 3 was conducted. The ne concentrator was hanging ble and the cannula end was not bagged. n., another observation was change from the previous n., an observation was made was in the bed asleep. The to the bed. The oxygen hat hangs on the wheelchair seat of the wheelchair, shoes which were in the seat ne cannula end was not n., in an interview with LPN al Nurse) the resident's estated it should have been ped around his shoes. n., the Administrator Member [ASM] #1) and the ASM #2) were made aware rther information was	F 32	28		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER	L		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116	1 03/	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334 F 334 SS=E	(1) Influenza. The fact and procedures to en (i) Before offering the each resident or their receives education repotential side effects (ii) Each resident is or immunization Octobe annually, unless the in	EUMOCOCCAL (2) umococcal immunizations ility must develop policies sure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically e resident has already been		3334			5/26/17
	has the opportunity to (iv) The resident's me documentation that in following: (A) That the resident was provided educati and potential side effe immunization; and (B) That the resident immunization or did n immunization due to r refusal.	or resident's representative on regarding the benefits					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C	
	ROVIDER OR SUPPLIER		D. WIING	s 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY 1ECHANICSVILLE, VA 23116	<u> 05/0</u>	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	(i) Before offering the immunization, each representative receive benefits and potential immunization; (ii) Each resident is or immunization, unless medically contraindical already been immunization that in following: (iii) The resident or the has the opportunity to the immunization that in following: (A) That the resident was provided educati and potential side effection immunization; and (B) That the resident pneumococcal immunization; and (B) That the resident pneumococcal immunization or rethis REQUIREMENT by: Based on resident in facility document revireview, the facility stappior to the administrator five of 27 resident Residents # 10, # 4, #	procedures to ensure that- pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; e resident's representative or refuse immunization; and edical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of pneumococcal either received the nization or did not receive munization due to medical fusal. i is not met as evidenced terview, staff interview, ew and clinical record ff failed to provide education ation of the influenza vaccine is in the survey sample,	F	334	F334 1. The facility cannot demonstrate the education on immunizations was provide to residents #3, #4, #6, #7 and #10. 2. All residents have the potential to affected by this deficient practice. 3. The Director of Nursing educated Nursing Managers and Supervisors, and	ded be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING		C 05/04/2017	
NAME OF P	ROVIDER OR SUPPLIER	100110	1	STREET ADDRESS, CITY, STATE, ZIP C	•	
TO UNE OF T	NOVIDEN ON OUT FIEN			7600 AUTUMN PARKWAY		
AUTUMN	CARE OF MECHANIC	SVILLE		MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 334	Continued From pa	age 129	F3	334		
	· ·	had received education prior		the Admissions staff on obt	aining	
		on of the flu vaccine.		consents for immunizations	s and providing	
	2 The facility staff	failed to provide Resident #4		education on influenza price administration of the vaccir		
		's representative education		4. The DON or designee		
		fits and potential side effects		admissions 5 times a week		
	of the influenza imr	munization during the		assure that education and	consents have	
	2016/2017 flu seas	son.		been given and obtained p		
	0 Th - f - :!!! + - #	failed to manide advention		Results of audits will be tak		
		failed to provide education stration of the influenza vaccine		committee monthly for 3 m review and revision as nee		
	for Resident # 3.	stration of the influenza vaccine		5. Date of compliance: J		
		failed to have evidence of the sent for an influenza vaccine				
	education was prov	failed to evidence that vided prior to Resident # 6's accine. In addition, the sent to refuse the vaccine was the clinical record.				
	The findings includ	e:				
	1/14/16 and again included, but were dementia, anxiety, coronary artery dis	as admitted to the facility on on 4/14/17 with diagnoses that not limited to, hypertension, depression, atrial fibrillation, ease, seizures, and ow functioning thyroid (1)].				
	set) was a significa ARD (assessment Resident # 10 was understanding and others. Resident #	est recent MDS (minimum data ant change assessment with an reference date) of 4/21/17. coded as usually as usually able to understand 10 was coded as scoring zero 5 on the BIMS (Brief Interview				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
	495413	B. WING		C 05/04/2017
	ı			1 03/04/2017
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
for Mental Status) in was severely cognitive Review of Resident documented that sho on 10/8/16. No documented that sho documented that s	dicating that Resident #10 vely impaired. # 10's clinical record e had received the flu vaccine umentation of the consent or be found. by interview on 5/3/17 at 5:30 inistrative staff member) # 1, SM # 2, the director of gional director of clinical egistered nurse) # 3, the rdinator, this concern was on 5/4/17 at approximately # 2, ASM # 2 stated that no ould be found. Iffluenza Vaccine - Resident" ler "POLICY: All residents will niza vaccine beginning in ar, unless medically ler resident has already been illity will provide educational g the significant risks and let on the resident and/or le party annually." Under Consent for the influenza ned by the Admissions e) upon the resident's illity. In the event of weekend significant consent (Form in the resident's chart with a	F 33-	4	
	SUMMARY S (EACH DEFICIENT REGULATORY OF STEED OF	A95413 ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 130 for Mental Status) indicating that Resident #10 was severely cognitively impaired. Review of Resident # 10's clinical record documented that she had received the flu vaccine on 10/8/16. No documentation of the consent or the education could be found. During the end of day interview on 5/3/17 at 5:30 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nurses, ASM # 3, regional director of clinical services, and RN (registered nurse) # 3, the transitional care coordinator, this concern was	ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 130 for Mental Status) indicating that Resident #10 was severely cognitively impaired. Review of Resident # 10's clinical record documented that she had received the flu vaccine on 10/8/16. No documentation of the consent or the education could be found. During the end of day interview on 5/3/17 at 5:30 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nurses, ASM # 3, regional director of clinical services, and RN (registered nurse) # 3, the transitional care coordinator, this concern was revealed. During an interview on 5/4/17 at approximately 8:00 a.m. with ASM # 2, ASM # 2 stated that no consent/education could be found. The facility policy "Influenza Vaccine - Resident" was reviewed. Under "POLICY: All residents will be offered an influenza vaccine beginning in October of each year, unless medically contraindicated or the resident has already been vaccinated. The facility will provide educational information regarding the significant risks and benefits of the vaccine to the resident and/or residents' responsible party annually." Under "PROCEDURE: A. Consent for the influenza vaccine will be obtained by the Admissions director (or designee) upon the resident's and sidney of the consent. B. The completed consent (Form 5.5) will be placed on the resident's chart with a copy of the consent forwarded to the DON to ensure follow up. C. The Social Service director	ROVIDER OR SUPPLIER CARE OF MECHANICSVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE MECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 130 for Mental Status) indicating that Resident #10 was severely cognitively impaired. Review of Resident # 10's clinical record documented that she had received the flu vaccine on 10/8/16. No documentation of the consent or the education could be found. During the end of day interview on 5/3/17 at 5:30 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nurses, ASM # 3, regional director of clinical services, and RN (registered nurse) # 3, the transitional care coordinator, this concern was revealed. During an interview on 5/4/17 at approximately 8:00 a.m. with ASM # 2 stated that no consent/education could be found. The facility policy "Influenza Vaccine - Resident" was reviewed. Under "POLICY: All residents will be offered an influenza vaccine beginning in October of each year, unless medically contraindicated or the resident has already been vaccinated. The facility will provide educational information regarding the significant risks and benefits of the vaccine to the resident and/or residents' responsible party annually." Under "PROCEDURE: A. Consent for the influenza vaccine will be obtained by the Admissions director (or designee) upon the resident's admission to the facility. In the event of weekend or after hour's admission the admitting nurse will obtain consent. B. The completed consent (Form 5.5) will be placed on the resident's chart with a copy of the consent forwarded to the DON to ensure follow up. C. The Social Service director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER	L		S1 76	TREET ADDRESS, CITY, STATE, ZIP CODE 500 AUTUMN PARKWAY ECHANICSVILLE, VA 23116	05/	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	education regarding to side effects of the inflicit in the beginning of Se Service Director (or deprovision of education record" Review of the blank of "INFORMED CONSE VACCINE" document you should get vaccinget vaccinated?" and Effect/Negative Outco Vaccine." No further information of the provision of education and the provision of education and the provision of the provis	e party with information and the benefits and potential uenza vaccine, every year, eptemberD. The Social esignee) will document the in the resident's medical consent (Form 5.5), enterent form the following: "Why nated?" "When should you "Potential Adverse omes of Receiving the enterent form to exit. Its should receive trivalent exaccine (TIV) annually on. In the majority of ome available to long-terming in September, and should commence as soon e. Informed consent is ta standing order for loes not necessarily mean a	F	334			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, 56.25.	_		(
		495413	B. WING _			05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		70	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 334	and Medicaid prograr influenza and pneumodocument the results each resident is to be contraindicated medic representative refuse is not available becausinformation is to be remained to be a minimum Data Set, whealth parameters. Information obtained highly staff parameters. Information obtained highly staff fair and or the resident's regarding the benefits of the influenza immu 2016/2017 flu season. Resident #4 was adm 1/21/15. Resident #4 were not limited to: he depressive disorder and Resident #4's most reset), a quarterly asses (assessment reference the resident's cognition Section O documente influenza vaccine in the second in the s	es participating in Medicare ms to offer all residents ococcal vaccines and to a According to requirements, a vaccinated unless cally, the resident or legal as vaccination, or the vaccine ase of storage. This aported as part of the CMS which tracks nursing home from flu/professionals/infectioncon as obtained from the alm.nih.gov/medlineplus/enc led to provide Resident #4 representative education and potential side effects inization during the active to the facility on 's diagnoses included but be art failure, major and overactive bladder. acent MDS (minimum data assement with an ARD assembly	F	334			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 05/04/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	·	05/04/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 334	reveal evidence that resident's represent regarding the benef of the influenza vaco. On 5/3/17 at 5:42 p. member) #1 (the addirector of nursing), of clinical services) (the transitional care aware of the above On 5/4/17 at 8:00 at conducted with RN assistant director of development coordinates of the above of the ab	#4's clinical record failed to t Resident #4 and or the ative were provided education its and potential side effects cine. m., ASM (administrative staff ministrator), ASM #2 (the ASM #3 (the regional director and RN (registered nurse) #3 e coordinator) were made	F 3					
	dated 9/2/16 and mathe consent form wathe facility as soon a stated the form coul receptionist or chargeach unit. RN #1 stof the education in r#1 was asked to proresidents/representeducation regarding the 2016/2017 influed a copy of the letter a residents' families. provide evidence the were provided influed.	ailed on 9/3/16. RN #1 stated as supposed to be returned to as possible and the letter d be returned to the ge nurse/medication nurse on ated she did not place a copy esidents' clinical records. RN						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		405442	B. WING				0
		495413	B. WING			05/	04/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF MECHANICSV	ILLE		7	600 AUTUMN PARKWAY		
710101111				N	MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	the education was att could not validate res the letter nor could shareceived the letter between to accept the letter provided by documented, "Dear Families, In preparing for the upwe want to update yo be offering the flu vacas well as all new adr 1, 2016. Your consent is need vaccine. You are bein influenza vaccine influenza vaccine for the influenza vaccine Please fill out the attaform and return it to the possible. You may re Receptionist at the mourse/medication numentation of a vaccine consent vaccine. I understand to offer the flu vaccine for the responsible pagive permission for (aname to be written) rethe attending physicia section documented a GIVE my permission this vaccine"	ached. RN #1 stated she idents/representatives read he validate representatives cause the letters were not at RN #1 was dated 9/2/16 COCOMING Influenza season u on our process. We will ecine to all current residents, missions, beginning October and in order to administer this and provided with an armation statement from the Control (CDC) that will give ining to the benefits and risk ne. Inched consent/declination are facility as soon as eturn the form to the ain entrance or the charge	F	334			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 05/04/2017			
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE		
F 334		led to provide education	F	334					
	for Resident # 3.	ation of the influenza vaccine dmitted to the facility on							
	03/11/17 with diagnos not limited to: neurom cancer (1), gastroeso diabetes mellitus (3),	ses that included but were nuscular dysfunction of the phageal reflux disease (2), anxiety (4), depression, al fibrillation (6), glaucoma							
	set), a significant cha ARD (assessment ref coded Resident # 3 a interview for mental s - 15, nine being mode for making daily decis	ecent MDS (minimum data nge assessment with an ference date) of 03/16/17, s scoring a nine on the brief tatus (BIMS) of a score of 0 erately impaired of cognition sions. Resident # 3 was tensive assistance of one vities of daily living.							
	evidence Resident # was provided educati vaccine. Further revi signed consent dated Resident # 3's clinica	3's clinical record failed to 3 or their responsible party on about the influenza ew of the clinical did reveal a 1 9/12/16. Further review of I record revealed the s administered to Resident #							
	of staff development. responsible for compi and the CDC (Center	egistered nurse) # 1, ursing and previous director RN # 1 stated, "I was iling the influenza consent							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405442	B. WING			1	0
NAME OF B	20,425, 02, 01, 150, 150	495413	B. WING			05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP C 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 334	9/2/17 and mailed 9/3 returned to the facility of the resident's clinic provide evidence that Disease Control) influ provided to Resident RN # 1 stated that she evidence. On 05/04/17 at appro (administrative staff madministrator, and AS were made aware of the No further information References: 1. The uncontrolled gethe body. Cancerous malignant cells. This from the website: https://medlineplus.go. 2. Stomach contents the esophagus and in was obtained from the https://www.nlm.nih.go. 3. A chronic disease i regulate the amount of information was obtain https://www.nlm.nih.go. 001214.htm. 4. Fear. This informat website:	s. The letter was dated 3/17. The consent was to be 7, the education was not part 1/21 record." When asked to 1/21 the CDC (Center for 1/21 lenza education was 1/23 or their responsible party 1/22 e couldn't provide the 1/22 p.m. ASM 1/22 he member) 1/22 p.m. ASM 1/22	F	3334			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER			S 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY 1ECHANICSVILLE, VA 23116	<u> 03/</u>	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 334	obtained from the we https://www.nlm.nih.g essure.html. 6. A problem with the heartbeat. This information the website: https://www.nlm.nih.gon.html. 7. A group of disease optic nerve. This information the website: https://www.nlm.nih.gon.html. 8. Nerve damage. The from the website: https://www.google.co.du.the facility staff faireducation and consense for Resident #7. Resident #7 was admixing with diagnoses that in to: diabetes, high bloochronic pain, gastroes anemia (too low blood and consense for the facility staff faireducation and consense for Resident #7.	re. This information was bsite: lov/medlineplus/highbloodpr speed or rhythm of the mation was obtained from lov/medlineplus/atrialfibrillati s that can damage the eye's rmation was obtained from lov/medlineplus/glaucoma.ht lov/medlineplus/glaucoma.ht his information was obtained lom/#q=neuropathy+nih. led to have evidence of the lot for an influenza vaccine littled to the facility on 1/7/15 included but were not limited lod pressure, depression, sophageal reflux disease, di count (1)), pressure ulcer inflammation or sore over a	F	334			

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495413	B. WING		C 05/04/2017	
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 03/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 334	resident as scoring interview for mental she was severely in daily decisions. Res requiring extensive staff members for a living. Review of the clinic documentation of the education provided party prior to receivi 10/19/16. A request was made education and cons for Resident #7 on at 5:35 p.m. At the end of the dap.m. the concern for for the influenza vac administrative staff administrator, ASM ASM #3, the corpor transitional care coordinated of the consents and education and education and education and consents and education and education and education her role with #1 stated, "I was remailing to the family consisted of a letter form and the CDC (education sheet." T	a zero on the BIMS (brief status) score, indicating that inpaired to make cognitive sident #7 was coded as assistance of one or more ill of her activities of daily all record failed to evidence be influenza consent and to the resident or responsible ing the influenza vaccine on the influenza vaccine on the influenza vaccine on the influenza vaccine of the ent for the influenza vaccine of the ent for the influenza vaccine of the influenza vaccine of the influenza vaccine of the ent for the ent	F 33	34		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		495413	B. WING		C 05/04/2017		
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
F 334	stated, "No. The conto the facility as soon on to say, "The const the receptionist, charnurse on the unit." At RN #1 that there was education part in the stated, "Correct, I car (responsible party) of education. The only consent." When aske the consent, RN #1 state legal clinical record documenting that the stated, "No." No further information (1) Barron's Dictional Non-Medical Reader Chapman, page 33. (2) Barron's Dictional Non-Medical Reader Chapman, page 155. 5. The facility staff fareducation was provided refusal of the flu vaccal Resident #6's consent maintained on the Resident #6 was admand readmitted on 12 but not limited to: midysphagia, osteomy was provided and readmitted and	It to the consents, RN #1 sent form was to be returned as possible." RN #1 went ents were to be returned to ge nurse, or medication this time it was verified with no documentation of clinical record, RN #1 n't evidence that the RP r resident received the thing returned is the ed if the letter is returned with stated, "No." When asked in rd, is there anything education was done, RN#1 In was provided prior to exit. Try of Medical Terms for the the thing returned with the ditter is returned with the ditter is returned with the difference that the difference that led prior to Resident # 6's cline. In addition, the int to refuse the vaccine was	F 33	4			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 05/04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 334	4/13/17. The resident impaired in ability to rescoring a 10 out of a (Brief Interview for Moresident was coded a transfers, dressing, a assistance for eating incontinent of bowel a catheter for bladder. A review of the above documented that the vaccine. A review of reveal any evidence of education, consent of the Administrator (Ad [ASM] #1) and the Di were made aware of On 5/4/17 at 7:30 a.m facility, a consent for the resident refused the education was documented that there education. On 5/4/17 at 7:45 a.m (Registered Nurse) the stated that there education. On 5/4/17 at 7:59 a.m ADON (Assistant Direstated that the consetthe clinical record, an education sheet that	ment Reference Date) of t was coded as moderately make daily life decisions, possible 15 on the BIMS ental Status) exam. The s requiring total care for and hygiene; extensive and bathing; and as and as having an indwelling e identified MDS resident had refused her flu the clinical record failed to of the resident's flu status, refusal. a., at the end of day meeting, ministrative Staff Member rector of Nursing (ASM #2) the findings. a., upon arriving to the m was provided indicating he vaccine on 10/20/16. No mented on this form. a., in an interview with RN #3 the Transitional Care Nurse, was no evidence of a., in an interview with the ector of Nursing, RN #1) she ints were not maintained on	F 33			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			1	C 04/2017
	ROVIDER OR SUPPLIER	ILLE	1	76	REET ADDRESS, CITY, STATE, ZIP CODE 00 AUTUMN PARKWAY ECHANICSVILLE, VA 23116		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	#1 and Director of Nu aware of the findings. provided by the end of	n., the Administrator, ASM rrsing, ASM #2 were made . No further information was of the survey.		334			5/26/17
SS=C	provided by the end of the survey. DISPOSE GARBAGE & REFUSE PROPERLY				F372 1. The dumpster area was cleaned immediately. 2. All residents have the potential to be affected by this deficient practice. 3. The Environmental Services Direct educated housekeeping, maintenance and dietary staff on the requirements for proper maintenance of the dumpster are 4. The Environmental Services Direct or designee will audit the dumpster are for cleanliness twice daily five times a week for four weeks and randomly for eight weeks to assure compliance. Results of audits will be reviewed by the QAPI committee for three months. 5. Date of compliance: June 16, 2017	tor or ea. tor a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495413	B. WING _		0	C 5/04/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	' '		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 372	around the dumpsters doors should be close immediately instructed dumpster area. On 05/04/17 at appro (administrative staff madministrator, and AS were made aware of the No further information DRUG REGIMEN REIREGULAR, ACT OCFR(s): 483.45(c)(1)(c) Drug Regimen Revelowed at least oncepharmacist. (3) A psychotropic drubrain activities associand behavior. These limited to, drugs in the (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-dapressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist mato the attending physical facility's medical direct and these reports multiple and the service and the content of the attending physical direct and these reports multiple and the content of the content	arther stated that the ground is should be clean and all ed. OSM #5 and OSM #5 d staff to begin cleaning the eximately 1:50 p.m. ASM nember) # 1 the ember of the findings. In was provided prior to exit. EVIEW, REPORT in was provided prior to exit. EVIEW, REPORT in was a month by a licensed end in a month by a licensed end with mental processes drugs include, but are not ember of the following categories: The provided that affects are a month by a licensed end with mental processes drugs include, but are not ember of the following categories: The provided that affects are and the ember of the provided in the common of the provided in the common of the provided in the common of the provided in the provided i		428		5/26/17	
	(i) in ogalarities molda	le, but are not limited to, any					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING _			05//) 04/2017
	ROVIDER OR SUPPLIER			70	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116	1 05/1	J4/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	(d) of this section for a (ii) Any irregularities of during this review museparate, written report attending physician and director and director and director and the irregularity the (iii) The attending phyresident's medical recirregularity has been taken be no change in the no physician should doct the resident's medical (5) The facility must do and procedures for the review that include, but frames for the different steps the pharmacist identifies an irregularity to protect the resident This REQUIREMENT by: Based on staff interview, and clinical redetermined that facility monthly medication recompleted; maintaine available for review and for nine of 27 resident Resident #2, #8, #9, #1. The facility staff fail	riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a port that is sent to the and the facility's medical of nursing and lists, at a at's name, the relevant drug, a pharmacist identified. resician must document in the cord that the identified reviewed and what, if any, and to address it. If there is to nedication, the attending ument his or her rationale in a record. Revelop and maintain policies are monthly drug regimen ut are not limited to, time and steps in the process and must take when he or she ty that requires urgent action it. The is not met as evidenced sew, facility document cord review, it was y staff failed to ensure	F	128	F428 1. Resident monthly Medication Revivere filed in the resident clinical record 2. All residents receiving medications have the potential to be affected by this deficient practice. 3. The Director of Nursing will in-serve nursing management and the medical records clerk on the process of filing monthly medication reviews. 4. The Director of Nursing or designed.	s. s rice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 5/ 04/2017	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODI 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	310412011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	and or maintained the Resident # 2. 2. The facility staff fair medication regimen in within the facility and and or maintained the Resident # 8. 3. The facility staff fair medication regimen in within the facility and and or maintained the Resident # 9. 4. The facility staff fair Resident # 1's monthly recommendation revious June 2016 through O have readily available monthly pharmacy moreviews in the resident months of November through April 2017. 5. The facility staff far Resident #4's August	readily available for review in the clinical record for led to ensure the monthly eviews were maintained readily available for review in the clinical record for led to ensure the monthly eviews were maintained readily available for review in the clinical record for led to provide evidence that y pharmacy medication ews were completed for ctober 2016 and failed to e for review and or maintain edication recommendation of the clinical record for the 2016 and January 2017	F 42	,	eekly for narmacy ire scanned s of audits mittee ew and		
	review and or maintal medication recommer resident's clinical reco November 2016 and 2017.	to have readily available for in monthly pharmacy ndation reviews in the ord for the months of January 2017 through April iled to have readily available ntain Resident #11's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING		C 05/04/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	/ILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 428	the resident's clinical 7. The facility staff fair medication regimen is conducted in Septemensure the monthly in for January through A within the facility and and or maintained the september 2017 with available for review a regimen reviews were record. 9. The facility staff fair monthly pharmacy in for January through A maintained within the review and or on the the September 2016 review was not composite of the september 2016. 1. The facility staff fair medication regimen is within the facility and	illed to evidence that the review for Resident #7 was aber 2016, and failed to medication regimen reviews April 2017 were maintained readily available for review in the clinical record. alled to maintain Resident imen reviews for January ithin the facility, readily and or ensure medication in the clinical maintained in the clinical sedication regimen reviews April of 2017, were a facility, readily available for clinical record. In addition, monthly medication regimen releted.	F 428			
	10/15/16 with diagno not limited to spinal s	nitted to the facility on ses that included but were stenosis, lymphedema, d right lower limb, atrial				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495413	B. WING _				04/2017
	ROVIDER OR SUPPLIER	ILLE		76	REET ADDRESS, CITY, STATE, ZIP CODE 00 autumn Parkway Echanicsville, va 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 428	blood pressure. Resi (minimum data set) w with an ARD (assess 1/19/17. Resident #2 cognitively intact in the decisions scoring 15 Interview for Mental Streview of the clinical Resident 2's monthly for January, February be found. On 5/3/17 at 1:55 p.m conducted with ASM member) #2, the DON When asked about the processing pharmacy that pharmacy will emand she will divide the them in a physician's will then have the revisignature. ASM #2 stated that s reviews because she facility. ASM #2 state made for January and followed. When asked with a serviews decause she facility. ASM #2 state made for January and followed. When asked with the mand she will divide the them in a physician's will then have the revisignature. ASM #2 stated that s reviews because she facility. ASM #2 stated made for January and followed. When asked	diabetes mellitus, and high dent #2's most recent MDS was a quarterly assessment ment reference date) of a was coded as being the ability to make daily out of 15 on the BIMS (Brief Status exam). Trecord revealed that medication regimen reviews was (administrative staff N (Director of Nursing). The process staff follows for the process reviews to her (the DON) the reviews by unit and place book. ASM #2 stated she	F	428			
		2's pharmacy ed 1/23/17 revealed the ation was made: "(Name of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495413	B. WING _			C 05/04/2017	
	ROVIDER OR SUPPLIER	VILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			1 33/34/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	(milligrams) every in Recommend admin with the evening me Review of Resident order sheet) revealed to "at bedtime" per pl. 1/23/17. Review of Resident recommendation da following recommendation da following recommer Resident #2) has a diphenhydramine (Enight), a high risk mrisk for prolonged stalls and anticholine Recommendations: discontinuing PRN desired, please con or prn trazadone [5]. Review of Resident orders revealed that on 3/17/17. On 5/3/17 at 1:55 p made aware of the state of the	receives Xarelto [1] 15 mg norning. Recommendation: istering Xarelto once daily eal." #2's active POS (physician ed that Xarelto was changed oharmacy recommendation on #2's pharmacy ted 3/16/17 revealed the dation was made: "(Name of PRN (as needed) order for Benadryl) [2] 50 mg qhs (every edication due to increased edation and increased risk for orgic [3] properties. Please consider diphenhydramine. If therapy sider initiating melatonin [4], ." #2's telephone physician t Benadryl was discontinued .m., ASM #2, the DON was	F 4	,			
	"Procedure: 1. The conduct MRRs if red Consultant Agreement that the Consultant 2.1 The resident an Responsible Party;	consultant Pharmacist will quired under a Pharmacy ent. 2. Facility should ensure Pharmacist has access to:					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							c
		495413	B. WING			05/	04/2017
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	7600 AUTUMN PARKWAY		
AUTUMN	CARE OF MECHANICSV	ILLE		ı	MECHANICSVILLE, VA 23116		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 428	Continued From page	118		428			
1 420		5 140		420			
	Applicable law;	atom, tooto					
	2.3 Resident's Labora						
		ber progress notes, nurses' uments which may assist the					
		st in making a professional					
		ther or not irregularities exist					
		imen; and 2.5 Any other					
	necessary information	•					
	Applicable Law.	n, in accordance with					
	3. Facility should info	rm the Consultant					
	Pharmacist of any ph						
		dent which are likely to affect					
	his/her medication the	erapy outcome.					
	4. Facility should ens	ure that the Consultant					
	Pharmacist has a qui	et, private location to					
	perform MRRs. Electi	ronic medication records					
	may permit the Consu	ultant Pharmacist to perform					
	some aspects of the I	MRR outside the Facility.					
		ependently review each					
		regimen directly from the					
		art and with interdisciplinary					
		, resident or Responsible					
	Party, as needed.						
	6. Facility should ens	-					
	_ <u></u>	rs are provided with copies				ĺ	
	of the MRRs.						
		ourage Physician/Prescriber					
		Parties receiving the MRR					
	and the Director of Nu	- ·				ĺ	
		ntained in the MRR. For				ĺ	
	-	uire Physician/Prescriber				ĺ	
	intervention, Facility s					ſ	
		to either, (a) accept and act				ſ	
	•	ations contained within the				ſ	
	MRR, or (b) reject all					ſ	
		ntained in the MRR and					
	provide an explanation						
	recommendation was						
	8. Facility should prov	vide the Medical Director					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————			ATE SURVEY DMPLETED			
		495413	B. WING			C 05/04/2017
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Medical Director who 9. Facility should ma in Facility, either as p	RRS and should alert the ere MRRs require follow-up. intain copies of MRRs on file part of the resident's ecord or in a special file, in	F 42	28		
	clots, which lowers thrombosis and pulminformation was obtainstitutes of health.	treat and prevent blood ne risk of stroke, deep vein nonary embolism. This nined from the National n.nih.gov/pubmedhealth/PMH etails.				
	symptoms of allergic cold. This informatio National Institutes of	tihistamine that is used for rhinitis and the common n was obtained from the Health. N/Diphenhydramine.htm.				
	mouth, constipation, obstruction, dilated processed heart rate function that is cause medications. This informal Institute	and impairment of cognitive ed by a wide variety of formation was obtained from				
	role in sleep. Melato used for those with s trouble falling asleep	tural hormone that plays a nin dietary supplements are sleep disorders or have b. This information was ational Institutes of Health. health/melatonin.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 04/2017
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00	04/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	depression that can	antidepressant used to treat cause sleepiness. .nih.gov/pubmedhealth/PMH	F 42	28		
	medication regimen within the facility and	iled to ensure the monthly reviews were maintained readily available for review e in the clinical record for				
	10/18/16 with diagnorm not limited to: stroke, major depressive disparalytic gait and mumost recent MDS (muguarterly assessment reference date) of 3/coded as being cogn to make daily decision the BIMS (Brief Interexam. Resident #8 wassistance from one	nitted to the facility on ses that included but were type two diabetes mellitus, order, anxiety disorder, scle spasms. Resident #8's inimum data set) was a t with an ARD (assessment 17/17. Resident #8 was itively impaired in the ability ons scoring 06 out of 15 on view for Mental Status) vas coded as extensive staff member with transfers, hygiene, and bathing; and ing.				
	Resident #8's month	l record revealed that ly medication regimen February, March and April of und.				
	When asked about the monthly pharmacy re					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	COMP	(X3) DATE SURVEY COMPLETED	
		495413	B. WING			C 04/2017
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	physician book for rethe reviews will then signature and she w to medical records to ASM #2 provided thi January, February, I pharmacy reviews. review came from, A have to check. Review of Resident: April 2017 monthly revealed no recommonths. Review of Resident's regimen review for I recommendation tha "Comment: After rev #8) chart, there appeand/or documentation which supports contimedication(s): "Topa seizures or mood? Fere-evaluate continue documentation in thi record which suppor routine use of this/th forward." Review of Resident: (physician order she 4/30/17 revealed the Tablet 25 mg (milligned).	m by unit and put them in the eview." ASM #2 stated that get sent back to her for her ill give the pharmacy reviews of file in the clinical record. Is writer with Resident #8's March and April 2017 monthly when asked where each asked where each ask #2 stated that she would where the stated that she would where the stated that she would held to be a stated that she would where the stated that she would held that she woul	F 4:	28		
	Tablet 25 mg (milligr at bedtime for Antico initiated on 12/31/16	ams) Give 2 tablet by mouth onvulsant." This order was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV			S 7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u> U5/</u>	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	ASM #2 stated that R February, and March were scanned to her ASM #2 stated that si reviews and had phan ASM #2 stated that R pharmacy review was records office. ASM is records had not yet fi When asked if the fac 2017 recommendatio stated, "I can check of diagnosis was added On 5/4/17 at 10:30 a. Resident #8 was rece and a new diagnosis (physician order shee recommendation. AS not revised around th On 5/4/17 at 10:30 a. aware of the above of information was prese [1] Topamax is used to and children and also medication for the tre This information was Institutes of Health. https://www.ncbi.nlm. 71954/. 3. The facility staff fai medication regimen r within the facility and	#2, the director of nursing. Resident #8's January, 2017 pharmacy reviews from pharmacy that day. The could not find these remacy resend them to her. Resident #9's April 2017 in a folder in the medical resident #2 stated that medical red this pharmacy review. Stility had followed the March of the Topamax, ASM #2 on that to see if a new resident make the resident makes and added to the POS ret) per pharmacy makes at time. The order was at time. The resident makes and added to the post of the po	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495413	B. WING		05/04/2017	,
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLE	ETION
F 428	4/20/15 and readmit diagnoses that incluing Fracture of unspecific femur, difficulty in was dementia, major deposition of the cent MDS (minimum MDS with an ARD (and 1/2/17). Resident severely cognitively daily decisions. Review of the clinical Resident #9's month reviews for January, 2017 could not be for the conducted with ASM member) #2, the DC When asked about the monthly pharmacy reviews are emailed will sort through their physician book for rethe reviews will then signature and she with the medical records to ASM #2 provided this January, February, In pharmacy reviews.	mitted to the facility on ted on 10/6/16 with ded but were not limited to fied part of neck of right alking, history of falling, pressive disorder, anxiety disorder. Resident #9's most am data set) was a quarterly assessment reference date) at #9 was coded as being impaired in the ability to make all record revealed that ally medication regimen. February, March and April of bund.	F 4:	28		
		#9's January, February, 7 monthly medication				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	ODE	30.0 11.20 11
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
F 428	during these months On 5/4/17 at 8:55 a.r Resident #9's Janua 2017 pharmacy revie from pharmacy that of could not find these resend them to her. #9's April 2017 pharm in the medical record medical records had review. On 5/3/17 at 8:55 a.r of the above findings presented prior to ex 4. The facility staff fa Resident #1's month recommendation rev June 2016 through O have readily availabl monthly pharmacy m reviews in the reside months of November through April 2017. Resident #1 was adr 10/17/16. Resident a were not limited to: A overactive bladder a Resident #1's most r set), a quarterly asse (assessment referen the resident as being Review of Resident as	m., ASM #2 stated that ry, February, and March was were scanned to her day. ASM #2 stated that she reviews and had pharmacy ASM #2 stated that Resident macy review was in a folder as office. ASM #2 stated that not yet filed this pharmacy m., ASM #2 was made aware as No further information was it. illed to provide evidence that by pharmacy medication iews were completed for october 2016 and failed to be for review and or maintain redication recommendation int's clinical record for the record for	F4	128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER	12 1		STREET ADDRESS, CITY, STATE, ZIP C 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	03/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 428	review dated 12/16/1 medication recomme observed in the clinic p.m., OSM (other star records employee) promedication recomme 1/23/17, 2/24/17, 3/16 On 5/3/17 at 2:00 p.m. conducted with ASM member) #2 (the direstated many of the more recommendation revirecord. ASM #2 stated in the medical recordwere sent from the plant the reviews should be #2 stated a day or two completes the reviews reviews to her (ASM divides the reviews be reviews with recommendations with no recommendations with recommendations wi	6. No other monthly ndation reviews were al record. On 5/3/17 at 2:35 ff member) #23 (the medical resented monthly pharmacy ndation reviews dated 6/17 and 4/10/17. 1., an interview was (administrative staff ctor of nursing). ASM #2 conthly pharmacy medication reviews were not in the clinical red some of the reviews were so office and some reviews narmacy. ASM #2 confirmed in the clinical record. ASM to after the pharmacist emails the review en units and between rendations and reviews with a ASM #2 stated she retween units and between rendations are addressed the reviews and takes them as department. ASM #2 stated reviews and takes them as department. ASM #2 esupposed to be scanned red within a week after they cal records department. 1., ASM #1 (the #2, ASM #3 (the regional vices) and RN (registered onal care coordinator) were	F	128		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495413	B. WING		C 05/04/2017
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	1 00/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 428	review dated 11/7/16 lying on the table in taddressed to this sur. On 5/4/17 at 8:20 a.m. this surveyor still need reviews for June 201 September 2016 and stated her understand didn't find the reviews them and she was unthe previous pharmacy november 2016. No further information (1) "Alzheimer's disect common form of dem Dementia is a brain of a person's ability to on This information was https://vsearch.nlm.nmeta?v%3Aproject=rmedlineplus-bundle&_ga=2.192845283.85 20270.1477942321 (2) "Lymphedema is swelling. It happens your body's soft tissue contains white blood germs" This inform website: https://medlineplus.g.	dication recommendation was presented in a folder he conference room and veyor. n., ASM #2 was made aware ded to see Resident #1's 6, July 2016, August 2016, 1 October 2016. ASM #2 ding was that if facility staff is then the facility didn't have hable to get information from toy that provided services began services in n was presented prior to exit. ase (AD) is the most mentia among older people. disorder that seriously affects farry out daily activities" obtained from the website: ih.gov/vivisimo/cgi-bin/query- medlineplus&v%3Asources= query=alzheimers+disease& 53609700.1494263454-1391 the name of a type of when lymph builds up in less. Lymph is a fluid that cells that defend against mation was obtained from the	F 42	8	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405442	B. WING			l	0
		495413	B. WING	_		05/	04/2017
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN (CARE OF MECHANICSV	ILLE		7	7600 AUTUMN PARKWAY		
7101011111				1	MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	<u> </u>		1		· ·		
F 428	Resident #4's August medication recommer completed and failed review and or maintai medication recommer resident's clinical recommer.	2016 monthly pharmacy ndation review was to have readily available for n monthly pharmacy ndation reviews in the	F	428			
	were not limited to: he depressive disorder a Resident #4's most reset), a quarterly asset (assessment reference	's diagnoses included but eart failure, major nd overactive bladder. ccent MDS (minimum data					
	monthly pharmacy me	ndation reviews were					
	presented Resident # medication recommer months of November ASM #2 stated many medication recommer the clinical record. As reviews were in the mome reviews were so ASM #2 confirmed the	(administrative staff ctor of nursing). ASM #2 4's monthly pharmacy ndation reviews for the 2016 through April 2017. of the monthly pharmacy ndation reviews were not in SM #2 stated some of the nedical records office and ent from the pharmacy. e reviews should be in the #2 stated a day or two after					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495413	B. WING _			C 05/04/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP COI 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	313-1123-11	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	ASM #2 stated she dunits and between reand reviews with nor stated reviews with nor directly walked to the department. ASM #2 recommendations are off on the reviews and records department. are supposed to be serecord within a week medical records department. ASM #3 director of clinical sernurse) #3 (the transitional made aware of the absolute of the absolute of the absolute of the previews then the she was unable to ge previous pharmacy the new pharmacy begar 2016. No further information of the facility staff facility	e reviews to her (ASM #2). Ivides the reviews between views with recommendations ecommendations. ASM #2 or recommendations are medical records stated reviews with e addressed then she signs d takes them to the medical ASM #2 stated the reviews canned into the medical after they are taken to the intrment. In., ASM #1 (the #2, ASM #3 (the regional vices) and RN (registered onal care coordinator) were pove findings. In., ASM #2 was made aware ded to see Resident # 4's ASM #2 stated her that if facility staff didn't find facility didn't have them and to information from the that provided services until a that services in November In was provided prior to exit. It illed to have readily available intain Resident #11's in April 2017 monthly in recommendation reviews in	F 4	28			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		495413	B. WING				04/2017
	ROVIDER OR SUPPLIER	ILLE	•	7	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	7/10/15. Resident #1 were not limited to: che diabetes and major done Resident #11's most is set), a quarterly asse (assessment reference the resident's cognitic Resident #11's compon 3/14/16 failed to done regarding monthly phorecommendation revisions which was a series of the resident #10 failed to done regarding monthly phorecommendation revisions which was a series of the review monthly pharm recommendation revisions which was a series of the february 2017 through the february 2017 and A con 5/3/17 at 2:35 p.m member) #23 (the maprovided reviews for the february 2017 and A con 5/3/17 at 2:00 p.m conducted with ASM member) #2 (the direct stated many of the more recommendation revisions and the medical records were sent from the phore the reviews should be #2 stated a day or two completes the reviews to her (ASM sidvides the reviews be reviews with recommendations or recommendations.)	mitted to the facility on 1's diagnoses included but nronic kidney disease, epressive disorder. recent MDS (minimum data assment with an ARD be date) of 4/13/17, coded on as severely impaired. rehensive care plan initiated ocument information armacy medication ews. 11's clinical record failed to macy medication ews for the months of a April 2017. 11., OSM (other staff edical records employee) the months of January 2017, pril 2017. 12., an interview was	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u>'</u>	00/04/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	reviews with recomment then she signs off on to the medical record stated the reviews are into the medical record are taken to the med. On 5/3/17 at 5:42 p.m. administrator), ASM adirector of clinical senurse) #3 (the transit made aware of the all #11's March 2017 rev 5/4/17 at 7:45 a.m., Uninto the facility, the rewas present in a file and sitting on the table. No further information. 7. The facility staff farmedication regimen in conducted in Septemensure the monthly infor January through A within the facility and and or maintained the Resident #7 was administration. Resident #7 was administration in gastroes.	department. ASM #2 stated dendations are addressed the reviews and takes them als department. ASM #2 de supposed to be scanned and within a week after they ical records department.	F 4	28		
	of the sacral region (i	inflammation or sore over a sulting from prolonged				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED
		495413	B. WING		C 05/04/2017
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	03/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 428	assessment, a quant assessment reference resident as a zero of mental status) score severely impaired to decisions. Review of the clinic documentation of the regimen (MRR) rev September 2016, Ji 2017. A request was made time frame on 5/2/1 The MRRs for January presented on 5/3/13 staff member (ASM stated that if the on survey team are black (the facility) had to greatly had t	obs (minimum data set) terly assessment, with an ince date of 2/3/17, coded the in the BIMS (brief interview for e, indicating that she was o make cognitive daily all record did not reveal any ne monthly medication iews being completed in anuary 2017, March and April e for the MRRs for the above	F 42	8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING		-		04/2047
	ROVIDER OR SUPPLIER		1	7	STREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	<u> U5/</u>	04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	records to scan into the record." When asked clinical record, ASM # Administrative staff meadministrator, ASM # ASM #3, the corporate transitional care coord the above findings on the above findings and the above findings are above findings on the above findings are above findings on the above findings are above findings on the above findings on the above findings are above findings on the above findings are above findings on the above findings of the above	give them to medical the electronic medical why they were not in the #2 stated, "I don't know." ### were mot in the #2 stated, "I don't know." ### were mot in the #2 stated, "I don't know." ### were mot in the ### 22, the director of nursing, ### enurse and RN #3, the ### dinator, were made aware of ### 5/3/17 at 5:35 p.m. ### was provided prior to exit. ### yof Medical Terms for the ### 5th edition, Rothenberg and ### will be did to maintain Resident ### men reviews for January ### thin the facility, readily ### not or ensure medication ### amaintained in the clinical ### mitted to the facility on ### nission on 11/21/16. Her	F	428			
	breathing while some chronic obstructive pu and atrial fibrillation (r contractions of the atr	one sleeps (1)), anemia, ulmonary disease (COPD),					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICS	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	DDE	1 00/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA	
F 428	assessment, a quarte assessment reference resident as scoring a interview for mental swas cognitively intact. Review of the clinical reveal any document medication regimen (completed in January A request was made time frame on 5/2/17 Copies of the MRRs 2017 were presented 7:30 a.m. An interview was constaff member (ASM) on 5/4/17 at 8:50 a.m. Resident #14's MRR: #2 stated, "They were We got them reprinted When asked about the MRRs in the faciliare emailed to me. I unit. They are given in the doctor's books they are given back thave received them is record." When asked clinical record, ASM is asserted.	S (minimum data set) erly assessment, with an e date of 3/14/17, coded the 14 on the BIMS (brief status) score, indicating she t to make daily decisions. I record on 5/3/17, did not ration that the monthly MRR) reviews were y through April 2017. for the MRRs for the above at 6:09 p.m. for January through April I to this surveyor on 5/4/17 at inducted with administrative #2, the director of nursing,	F 4	128		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495413	B. WING		05/04/2017	
	ROVIDER OR SUPPLIER CARE OF MECHANICS	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	00/04/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC	
F 428	copies of MRRs on the resident's perma special file, in accor	"Facility should maintain file in Facility, either as part of anent medical record or in a dance with Applicable Law." 2 were made aware of the	F 42	3		
	Non-Medical Reade Chapman, page 45. (2) Barron's Dictiona	ary of Medical Terms for the r, 5th edition, Rothenberg and				
	monthly pharmacy r for January through maintained within th review and or on the	e facility, readily available for e clinical record. In addition, one monthly medication regimen				
	and readmitted on 1 but not limited to: m dysphagia, osteomy neurogenic bladder. (Minimum Data Set) with an ARD (Asses 4/13/17. The reside impaired in ability to scoring a 10 out of a (Brief Interview for Market 1975).	mitted to the facility on 5/6/16 2/30/16 with the diagnoses of ultiple sclerosis, quadriplegia, relitis, pressure ulcers and The most recent MDS was a quarterly assessment sment Reference Date) of ent was coded as moderately make daily life decisions, a possible 15 on the BIMS Mental Status) exam.				
		t #6's clinical record failed to macy reviews for January				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		E SURVEY PLETED
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	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	03	5/04/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431 SS=D	of Nursing - ASM [Ad #2) On 5/3/17 at 2:00 p.m reviews for January the provided. The DON is the clinical record, and them over. When as 2016 review, she state the control of the state on 5/4/17 at 1:52 p.m (Administrative Staff I Director of Nursing with findings. No further in the end of the survey DRUG RECORDS, L. BIOLOGICALS CFR(s): 483.45(b)(2). The facility must providings and biologicals them under an agree §483.70(g) of this part unlicensed personnel law permits, but only supervision of a licential of the part of the par	ne monthly pharmacy ed from the DON (Director ministrative Staff Member] n., the monthly pharmacy prough April 2017 were estated that they were not on d that the pharmacy sent ked about the September ed there wasn't one. n., the Administrator Member [ASM] #1) and the ere made aware of the information was provided by ABEL/STORE DRUGS & (3)(g)(h) ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse.		431		5/26/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495413	B. WING _			C 05/04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		STREET ADDRESS, CITY, STATE, ZIP CO 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) (CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIA	
F 431	Continued From page	e 166	F 4	131		
	employ or obtain the pharmacist who	services of a licensed				
	disposition of all conti	tem of records of receipt and rolled drugs in sufficient curate reconciliation; and				
	(3) Determines that d that an account of all maintained and perio	•				
		s used in the facility must be e with currently accepted s, and include the y and cautionary				
	the facility must store locked compartments	h State and Federal laws, all drugs and biologicals in sunder proper temperature only authorized personnel to				
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distributed quantity stored is minded to be readily detected. This REQUIREMENT by: Based on observation	compartments for storage of d in Schedule II of the Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can is not met as evidenced on, staff interview and facility was determined that the		F431 1. The expired medication		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		405442	B. WING				0
NAME OF D	DOVIDED OD CUIDDUED	495413	B. WING	C-	TREET ADDRESS CITY STATE 7/D CODE	05/	04/2017
	ROVIDER OR SUPPLIER CARE OF MECHANICSV	ILLE		76	TREET ADDRESS, CITY, STATE, ZIP CODE 600 AUTUMN PARKWAY IECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	medications in two of (autumn and winter modications). The facility staff fail lorazepam oral concerefrigerator in the autumn acetylcysteine (2) is refrigerator in the wing the findings include: 1. On 5/2/17 at 1:50 pautumn medication row (registered nurse) #4. lorazepam oral concerefrigerator. The ope on the bottle or the modication to the bottle. The instrution box documented, "Discovered according to the facility on 12/24/16. For lorazepam bottle was been discontinued." I lorazepam bottle of loraz	appropriately label and store four medication rooms, nedications rooms). Iled to label an open bottle of entrate (1), located in the aumn medication room. Iled to discard an open vial solution, located in the ter medication room. In a comparison of the some was conducted with RN. An open bottle of entrate was observed in the nodate was not documented anufacturers' box containing ctions on the manufacturers' scard opened bottle after 90 y label on the manufacturers' medication was sent to the RN #4 confirmed the open. RN #4 stated, "It's RN #4 was asked when the open expired. RN #4 stated, I don't know if it's in the	F	431	disposed of immediately. 2. All residents receiving medications have the potential to be affected by this deficient practice. 3. The DON or designee will educate licensed nurses on the disposal of expimedications. 4. The Unit Managers/designee will conduct audits of medications weekly frour weeks and then randomly for eight weeks to assure that expired medication are disposed of properly. Results of auxill be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. Date of compliance: June 16, 2017	red or t ons dits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413		B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	495415	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	04/2017
AUTUMN CARE OF MECHANICSVILLE			7	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	and Expiration of Med Syringes and Needles should ensure that med 4.1 Have an Expiration Have not been retained recommended by many guidelines5. Once a is opened, Facility shown and a state of the medication dates for one staff should record the medication contained shortened expiration of the medication contained shortened expiration of the medication root (licensed practical number acetylcysteine solution refrigerator. A sticker "Discard 4 days after open date was hand we "4/11/17." LPN #2 state medication was distinguished the previous week. We medication should be "Four days after open medication should be stated, "No." On 5/3/17 at 5:42 p.m member) #1 (the admidirector of nursing), A of clinical services) are	policy titled, "5.3 Storage dications, Biologicals, s" documented, "4. Facility edications and biologicals: on Date on the label; 4.2 ed longer than nufacturer or supplier any medication or biological ould follow reguidelines with respect to pened medications. Facility edate opened on the when the medication has a date once opened" In was provided prior to exit. In was provided prior to exit. In was observation of the mass conducted with LPN rese) #2. A vial of no was observed in the root the vial documented, opening. Date opened "The written and documented ated the resident prescribed ischarged from the facility	F	431			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495413	B. WING		1	C	
NAME OF DE	ROVIDER OR SUPPLIER	433413	B: Willo	STREET ADDRESS, CITY, STATE, ZIP CODE	05/	/04/2017	
AUTUMN CARE OF MECHANICSVILLE			7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441 SS=F	"Storage of Opened North Contain an antimicrob taken to minimize consolution. If only a port used, store the remail use for inhalation only information was obtain http://labeling.pfizer.cd 4101 No further information (1) lorazepam oral coanxiety. This information website: https://dailymed.nlm.rm?setid=BF265C2E-A644D (2) acetylcysteine is used abnormal mucous see was obtained from the https://dailymed.nlm.rm?setid=5558a5f5-e886 INFECTION CONTROLLINENS CFR(s): 483.80(a)(1)(a)	roduct insert documented, //ials: This product does not ial agent, and care must be ntamination of the sterile ion of the solution in a vial is nder in a refrigerator and / within 96 hours" This ned from the website: om/ShowLabeling.aspx?id= n was presented prior to exit. ncentrate is used to treat tion was obtained from the hih.gov/dailymed/drugInfo.cf AB2F-42E5-96CF-3998EB5 used to treat patients with cretions. This information website: hih.gov/dailymed/drugInfo.cf B21-473b-7d8a-5d33d09f05 DL, PREVENT SPREAD,		131 141		5/26/17	
		blish an infection prevention (IPCP) that must include, at ving elements:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495413	B. WING _		- C - 05/04/2	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116		9.0 11.2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	investigating, and cor communicable disease volunteers, visitors, a providing services un arrangement based us conducted according accepted national state implementation is Photocommunication of the program, which limited to: (i) A system of surveit possible communication before they can sprease facility; (ii) When and to whom communicable disease reported; (iii) Standard and transt to be followed to previous formulation of the program of the progra	enting, identifying, reporting, introlling infections and ses for all residents, staff, and other individuals der a contractual inpon the facility assessment to §483.70(e) and following indards (facility assessment ase 2); In policies, and procedures in the individuals designed to identify ole diseases or infections and to other persons in the includents of the infections should be insmission-based precautions the infections; in the individual infections; in the individual infections; in the individual infections; in the individual infections; individual infections and to limited to:	F 4	41		

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 Continued From page 171 F 441 disease or infected skin lesions from direct	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 171 disease or infected skin lesions from direct STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 171 F 441 disease or infected skin lesions from direct		
disease or infected skin lesions from direct	(X5) COMPLETION DATE	
contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined, that the facility staff failed to maintain an effective infection control program as evidenced by incomplete and missing infection control logs. The facility staff failed to consistently document the infectious organisms on the infection control logs. There were no organisms documented on the log for the months of July, and August 2016, January and February 2017. Also the facility failed to evidence infection control tracking logs for May and June 2016. The findings include: The findings include: The findings include:		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	' '	E SURVEY PLETED
		495413	B. WING _			0.5	C 5/ 04/2017
	ROVIDER OR SUPPLIER	VILLE		76	REET ADDRESS, CITY, STATE, ZIP CODE 00 AUTUMN PARKWAY ECHANICSVILLE, VA 23116	1 00	70-712011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 441	documented titled of Resident name; cult (found in the culture from July 2016 to Al 2016 and June 2016 not included. The July 2016 infect that on 7/14/16 and urine cultures taken documented on the The August 2016 infect documented that on 8/19/16 8/26/16 and had urine cultures. In documented on the The January 2017 in documented that on one resident and urine another resident. Not documented on the The February 2017 documented on the The February 2017 documented on the The February 2017 documented that on residents had urine were documented on An interview was cop.m. with RN (regist	d's infection control logs plumns that included: ure (obtained) and organism (obtained). The infection control logs pril 2017 were reviewed. May be infection control logs were dion control log documented 7/7/16 two residents had (obtained). No organisms were log. Section control log (obtained) 8/8/16, 8/11/16 (obtained) 8/31/16 that six residents (obtained) 8/31/16 that six residents (obtained) 8/31/16 that six residents (obtained) 9/1/26/17 a stool specimen on the specimen as sent on obtained of organisms were log. Infection control log (obtained) 1/26/17 and 0/2/1/17 two cultures taken. No organisms on the log.	F 4	441	weekly for eight weeks. Results of aud will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. Date of compliance: June 16, 201		
	director of nursing. of the May 2016 and logs. RN #1 stated, June (infection contrasked if the organism was to be document	RN #1 was asked for a copy d June 2016 infection control "We couldn't find May and rol logs for 2016)." When m obtained from a culture ted on the infection control Yes. I will educate them on					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
		495413	B WING	D 14910		C
NAME OF PI	ROVIDER OR SUPPLIER	433413	5:	STREET ADDRESS, CITY, STATE, ZIP CODE		05/04/2017
				7600 AUTUMN PARKWAY		
AUTUMN CARE OF MECHANICSVILLE			MECHANICSVILLE, VA 23116			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	organisms on the logs our surveillance. We infected residents) on asked why this was d for trends." RN #1 stallook if it was necessal handwashing or perind. An interview was conp.m. with ASM (admirthe director of nursing organisms from cultur stated, "First of all we appropriately. We was	ny they documented the s, RN #1 stated, "It's part of take our grid and put it (the a map of each unit." When one, RN #1 stated, "We look sted that they would then ry to educate staff on seal care." ducted on 5/4/17 at 12:38 histrative staff member) #2,	F	441		
F 513 SS=D	Control Committee" of (infection control com 2. Review of surveilla infectious disease will committee by the Infe A. Monthly Infection of individual nursing unit infections by site and No further information X-RAY/DIAGNOSTIC RECORD-SIGN/DATIC CFR(s): 483.50(b)(2)(b) Radiology and oth (2) The facility must-	ection Control Coordinator. Control Log (Form 5) for t is used to and trend organism." I was provided prior to exit. REPORT IN	F	513		5/26/17

	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL						
		495413	B. WING _			05/	04/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	04/2017
ALITLIMAL	CARE OF MECHANICSV	u. i. e		76	00 AUTUMN PARKWAY		
AUTUWIN	CARE OF MECHANICSV	ILLE		ME	ECHANICSVILLE, VA 23116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 513	Continued From page	e 174	F 5	513			
F 513	dated reports of radio services. This REQUIREMENT by: Based on staff interv and clinical record reversed facility staff failed to fin clinical record for one survey sample, Resident was ordere with the facility staff failed to x-ray that was ordere with the findings include: Resident # 10 was and 1/14/16 and again on included, but were not dementia, anxiety, decoronary artery disea hypothyroidism [a low of the clinical physician order for a form Mental Status) cooks review of the clinical physician order for a further review of the clinical physician order further review of the clinical physician order furt	logic and other diagnostic is not met as evidenced iew, facility document review view, it was determined that le radiology results in the of 27 residents in the lent #10. It of file the results of a chest d on 4/20/17 in Resident Imitted to the facility on 4/14/17 with diagnoses that t limited to, hypertension, pression, atrial fibrillation, se, seizures, and functioning thyroid (1)]. recent MDS (minimum data change assessment with an ierence date) of 4/21/17.	F 5	513	F513 1. The results of the X-ray completed resident #10 on 4/20/17 were filed in the resident □s medical record. 2. All residents having X-rays have the potential to be affected by this deficient practice. 3. The DON or designee will in-service licensed nurses on the responsibility of filing radiology reports in the medical record. 4. The Unit Managers/designee will a radiology reports 5 times a week for 8 weeks to ensure part of clinical record. Results of audits will be taken to the Queommittee monthly for 3 months for review and revision as needed. 5. Date of compliance: June 16, 2016	ne t ce audit	
	chest x-ray report. During an interview o 11:40 a.m. with ASM	n 5/3/17 at approximately (administrative staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495413	B. WING			C 05/04/2017	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MECHANICSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116	•	3000-12011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 513	Continued From page	e 175	F 51	3			
		ector of nurses, a request ation of the chest x-ray					
	provided the chest x-	mately 2:00 p.m. ASM # 2 ray report and stated the scanned into the electronic					
	p.m. with ASM # 1, th ASM # 3, regional dir and RN (registered n	r interview on 5/3/17 at 5:30 le administrator, ASM # 2, lector of clinical services, lurse) # 3, the transitional leconcern was reviewed.					
	Policy" documented: Records shall be reta accordance with curre However, in the even are lost, destroyed by incomplete the Facilit the information to ma "PROCEDURE:C) administrator) and the or designee will recor by, but not limited to:	t health information records a actual disaster, or y will attempt to reproduce intain the record." Under the NHA (nursing home Medical Records Director estruct the health information 1. Reprinting or uploading undamaged databases (i.e.					
	No further information	n was provided prior to exit.					
	` '	was obtained from the nlm.nih.gov/medlineplus/enc					